WASHINGTON STATE RESPONDS

PROVIDING EDUCATIONAL INFORMATION ON HIV/AIDS & OTHER INFECTIOUS DISEASES AND REPRODUCTIVE HEALTH

AUGUST 2004

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The Washington State Department of Health HIV Prevention & Education Services, Client Services, and the Governor's Advisory Council on HIV/AIDS (GACHA) share a web address. Go to www.doh.wa.gov/hiv.htm for program access. You can also access the HIV Prevention & Education Services website at the old web address: www.doh.wa.gov/cfh/hiv_aids/prev_edu/.

Washington State Responds Quarterly Newsletter Now Electronically Distributed

Now that WSR is distributed electronically on our web site, we can send you an e-mail notification when the new issue is available online. In order to receive this notice please send your e-mail address with the subject title: WSR E-List. All you need to include in your note is your complete e-mail address. Please send to: barbara.schuler@doh.wa.gov.

HIV/AIDS Trainings to Meet State Licensing Requirements

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Anacortes (Skagit County)	(360) 299-1342 Jo Ann Hoover	4 hour 7 hour Video Courses	No charge	Offered by Island Hospital. For residents of Island, Skagit and San Juan Counties only.
Bellingham (Whatcom Co.)	(360) 733-3290	2.5 hour 4 hour 7 hour	$25 for 2.5 hr $40 for 4 hour $60 for 7 hour	Offered by the Whatcom County-Bellingham American Red Cross.
Bellingham (Whatcom Co.)	(360) 715-8350	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 7 hour	Offered quarterly through Bellingham Technical College.
Bellingham (Whatcom Co.)	(360) 715-8350	4 hour Infectious Disease Prevention for EMS	$30 for 4 hour	Offered quarterly through Bellingham Technical College.
Bremerton (Kitsap County)	(360) 377-7307	2.5 hour 4 hour 7 hour	$17.50 for 2.5 $25 for 4 hour $30 for 7 hour	Offered by Kitsap Home Care Services Training Center.
Bremerton (Kitsap County)	(360) 475-7359	2 hour	$10 for 2 hour	Offered by Olympic College in Bremerton.
Bremerton (Kitsap County)	(360) 377-3761	2.5 hour 4 hour 7 hour	$21 for 2.5 hr $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Bremerton (Kitsap and Pierce Counties)	(360) 405-0430 (253) 474-5879	2 hour 4 hour	$15 for 2 hour $15 for 4 hour	Offered by instructor Francis Hall. Also available in Pierce County.
Clallam County (Forks/Pt. Angeles)	(360) 374-5288 lanajrm@centurytel.net	3 hour 4 hour 7 hour	$25 for 3 hour $35 for 4 hour $55 for 7 hour	Offered by Olympic Community Health Associates. Scholarships available.
Clallam County (Port Angeles)	(360) 417-2352 K. McDaniel	2 hour	$10 for 2 hour	Offered by Clallam County Health Department.
Clark County (Vancouver)	(360) 693-5821	2 hour 4 hour 7 hour	$10 for 2 hour $20 for 4 hour $50 for 7 hour	Offered by the American Red Cross.
Colville (Ferry, Stevens and Pend Oreille Counties)	1-800-827-3218 Angie	2 hour 4 hour	No cost for 2 or 4 hour classes	Offered by Northeast Tri-County Health District.
Cowlitz County	(360) 414-5599	2 hour 4 hour 7 hour	$10 for 2 hour $30 for 4 hour $45 for 7 hour	Offered by Cowlitz County Health Department.
Coupeville (Island County)	(360) 678-5151	4 hour 7 hour	Call for info	Offered by Island County Health Department and Whidbey General Hospital.
Edmonds (Snohomish County)	(425) 640-1840	7 hour	$68 for 7 hour Also receive one credit.	Offered by Edmonds Community College.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Everett (Snohomish County)	(425)–259-9899 Anne Miles; Ext. 16 http:// www.pwnetwork.org/	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 5 hour	Offered by Positive Women's Network.
Everett (Snohomish County)	(425) 252-4103 Laura; Ext.12	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $30 for 4 hour $60 for 7 hour	Offered by the American Red Cross. Scholarships are available.
Grays Harbor	(360) 533-3431	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Grays Harbor and Pacific County	(360) 267-3404 (360) 267-3405	2 hour 4 hour 7 hour 10 hour	$25 for 2 hour $35 for 4 hour $55 for 7 hour $85 for 10 hr	Offered by Critical Incident Stress Management (CISM). They also offer First Aid/CPR classes.
Ilwaco (Pacific County)	(360) 642-2869 Lynn Roy	4 hour 7 hour	Cost varies	Offered by Ocean Beach Hospital.
Kirkland (King County)	(425) 739-8104 (425) 739-8112	7 hour	$69 for 7 hour	Offered by Lake Washington Technical College.
Mason County	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Mt. Vernon (Skagit County)	(360) 428-2151	4 hour 7 hour Videos	$25 handling fee for video tapes	Offered by Skagit Valley Hospital.
Mt. Vernon (Skagit County)	(360) 424-5291	2.5 hour 4 hour 7 hour	$25 for 2.5 hr $35 for 4 hour $45 for 7 hour	Offered by American Red Cross.
Mt. Vernon (Skagit County)	(360) 853-7742 www.healthsafepro. com	2.5 hour 4 hour 7 hour	$25 for 2.5 hr $40 for 4 hour $60 for 7 hour	Offered by Professional Health & Safety Consultants.
Okanogan	(509) 422-7153 Corina	2 hour 4 hour 7 hour	$10 for 2 hour $20 for 4 hour $35 for 7 hour	Offered by Okanogan Health District.
Olympia (Thurston County)	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Olympia	(360) 352-2375	4 hour 7 hour	$30 for 4 hour $60 for 7 hour	Offered by United Communities AIDS Network (UCAN).
Puyallup (Pierce County)	(253) 841-3311	2 hour 4 hour 7 hour	$15 for 2 hour $40 for 4 hour $50 for 7+ hour	Offered by H.E.L.P. (HIV/AIDS Educational Learning Place) the C.P.R. First Aid Company.
San Juan County	(360) 378-4474	2 hour 4 hour 7 hour	No charge for Island, Skagit and San Juan Counties	Offered by San Juan County Health & Community Services.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Seattle/King Co. & So. Snohomish Co.	(206) 784-5655 www.healthinfonetwork.org	2 hour 4 hour 7 hour	$10 for 2 hour $25 for 4 hour $40 for 7 hour	Offered by Health Information Network. They will also travel to your facility.
Seattle	800-783-2437	2.5 hour 4 hour 7 hour	$30.41 for 2.5 hr $45.44 for 4 hr $53.21 for 7 hr	Offered by Health Impact.
Seattle	(206) 726-3534	2 hour 4 hour 7 hour	$21 for 2 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Seattle	(206) 282-1288	7 hour	Call for info	Teen AIDS Prevention Education training for youth service providers, offered by YouthCare.
Spokane	(509) 326-3330 Ext. 210	2 hour 4 hour	$20 for 2 hour $30 for 4 hour	Offered by the American Red Cross.
Spokane	(509) 324-1542	7 hour	$50 for 7 hour	Offered by the Spokane Regional Health District.
Spokane	(509) 928-1588 Ext. 16	7 hour	$45 for 7 hour	Offered by Visions Community Resources.
Spokane	(509) 236-2430 Becky Nauditt	2 hour 4 hour	$18.00 $30.00	Community Health Access Services
Tacoma (Pierce County)	(253) 841-3311 Barbara Miller	2 hour 4 hour 7 hour	$30 for 2 hour $40 for 4 hour $50 for 7 hour	Offered by C.P.R. Company.
Tacoma (Pierce County)	(253) 474-0600	2 hour 4 hour 7 hour	$15 for 2 hour $43 for 4 hour $55 for 7 hour	Offered by the American Red Cross.
Tacoma (Pierce County)	(253) 566-5020 Linda Finkas	7 hour 7 hour Independent Study	$40 for 7 hour $45 for video course	Offered by Tacoma Community College.
Vancouver	(360) 992-2939 Press Option One	2 hour 4 hour 7 hour	$30 for 2 hour $50 for 4 hour $60 for 7 hour	Offered by Clark College Continuing Education Program. Take home program that offers discounts for 2 or more students.
Walla Walla	(509) 527-4330	7 hour	$45 for 7 hour	Offered quarterly by Walla Walla Community College.
Whitman County (Colfax)	(509) 397-6280	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
Whitman County (Pullman)	(509) 332-6752	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
White Salmon (Klickitat County)	(509) 493-1101	2 hour, 4 hour, 7 hour and other First Aid classes	$25 for 2 hour $30 for 4 hour $50 for 7 hour	Offered by Skyline Hospital.
Yakima	(509) 248-3628	7 hour	$50 for 7 hour	Offered by Planned Parenthood of Central Washington.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Yakima	(509) 457-1690	2 hour	$20 for 2 hour	Offered by the American Red Cross.
Yakima	(509) 853-2034 or 1-877-620-6202 http://www.fas-training.biz/	4 hour, 7 hour and other First Aid classes	$40 for 4 hour $55 for 7 hour	Offered by First Aids & Safety Training.
Statewide	(206) 784-5655 http://www.healthinfonetwork.org/	HIV/AIDS 7-hour Video Course	$250	Offered by Health Information Network. Designed to assist health care facilities meet Washington State Licensing requirements.
Statewide	(206) 543-1047	HIV/AIDS Training Audiotape	$95 for 7.5 hours	Offered by U of W School of Nursing. Designed to assist health care facilities to meet WA State requirements.
Statewide	(425) 564-2012	HIV/AIDS Self Study Program $100 Refundable Deposit	$60 for 4 hr. * $80 for 7 hr. *includes mailing	Offered by Bellevue Com. College Continuing Nursing Education and Health Information Network.
Statewide	(206) 320-9822	2 hour 4 hour 7 hour	$30 for 2 hour $45 for 4 hour $65 for 7 hour	Offered by the Empowerment Institute. Course may be offered at your site.
Statewide Internet Classes	(888) 804-7178 http://www.healthsafepro.com/	2.5 hour 4 hour 7 hour	$40 for 2.5 hr $40 for 4 hour $70 for 7 hour	Offered by Professional Health & Safety Consultants.
Statewide Internet Classes	(707) 937-0518 www.nursingceu.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Washington State HIV/AIDS internet course offered by Wild Iris Medical Education.
Statewide Internet Classes	1-800-346-4915 www.classesonline4u.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Online course offered by Prevention MD.
Statewide Internet Classes	(509) 628-1317 Kathleen Hayes www.designerwebsitesolutions.com	4 Hours	$40 for 4 hour	Online course offered by Designer Website Soltutions.

HIV Prevention Counseling and Testing Training Schedule for 2004

These one-, two- and three-day courses will assist health care providers and others develop necessary skills for providing pre- and post-test counseling for HIV testing, as required by Washington State law.

These courses are not intended for the general public.

Region	Trainer	Course Dates	
One (Spokane)	**Christopher Zilar** (509) 324-1542 or 1-800-456-3236 The cost varies according to length of class.	Sept. 14-15, 2004 Dec. 7-9, 2004	(2-day) (3-day)
Two (Yakima)	**Deborah Severtson-Coffin** (509) 454-3322 The cost for the 2-day class is $85.	Sept. 9-10, 2004 Oct. 21-22, 2004	(2-day) (2-day)
Three (Everett)	**Eric Hatzenbuehler and Kevin Henderson** (425) 339-5251 The cost for the 2-day class is $75.	Sept. 13-14, 2004 Nov. 8-10, 2004	(2-day) (3-day)
Four (Seattle)	**Robert Marks and Mark Alstead** (206) 296-4649 or e-mail to: diane.ferrero@metrokc.gov The cost for the 2-day class is $125. The cost fot the 3-day class is $175.	Aug. 3-5, 2004 Sept. 28-29, 2004 Nov. 2-4, 2004	(3-day) (2-day) (3-day)
Five (Tacoma)	**Kim Ingram** and **Moni Muraki** (253) 798-2939 The cost varies according to length of class.	*Sept. 16-17, 2004 Oct. 27-29, 2004 Nov. 15, 2004 * In Olympia	(2-day) (3-day) (1-day)
Six (Vancouver)	**Beth McGinnis** (360) 397-8111 The cost for the 2-day class is $100.	*Sept. 16-17, 2004 Nov. 3-5, 2004 * In Olympia	(2-day) (3-day)

Calendar

AUGUST 4, 2004

INDIAN WOMEN'S HEALTH AND MATERNITY CARE: PREVENTION IN NATIVE WOMEN

The target audience for this Albuquerque, New Mexico conference includes: leaders; health educators; and, medical and public health staff. There will be several nationally and internationally known faculty, as well as tracks on domestic violence, breastfeeding, and adolescent health. The conference dates are August 4, 5 and 6. E-mail kbreckinridge@salud.unm.edu or visit http://www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#August2004.

AUGUST 10, 2004

Public Health - Seattle & King County is offering two 2-day workshops on **Motivational Interviewing.** Motivational interviewing is a direct, yet non-confrontational counseling "style" for working with people who are ambivalent about changing their behaviors. This workshop will assist providers to: identify where clients are in the change process; recognize the right time to give information or advice; improve listening skills; create an environment that supports and encourages change; and, manage client resistance in a way that is less frustrating. Class dates are August 10 and 11. Fees are $95 per person. Agencies with 5 or more participants receive an $85 per person fee. Trainers are Robert Marks and Kathy Silverman. Contact Diane Ferrero at (206) 296-4649 or email diane.ferrero@metrokc.gov.

AUGUST 12, 2004

WOMEN OF COLOR, TAKING ACTION FOR A HEALTHIER LIFE - PROGRESS, PARTNERSHIPS AND POSSIBILITIES

This Washington, D.C. conference highlights important areas of women's health. This conference will: explore current prevention strategies that work; promote dialogue among multiple groups; foster partnerships to implement best practices; and, ensure that health issues of women of color remain at the forefront of national, state and local policy agendas. Conference dates: August 12 through August 15. Contact Elizabeth David at 202-205-0571 or http://www.4woman.gov/mwhs.

AUGUST 16, 2004

ESSENTIAL STD EXAM SKILLS

This **2-day workshop** focuses on **essential communication skills and examination techniques** used with patients at risk for STDs, through didactic and practicum training. The didactic portion (Day 1) includes *Sexual History Taking, Basic Male and Female Anatomy, Steps in the STD Exam, Prepping the Exam Room, Case Studies & Charting, and Microscopy.* During the practicum (Day 2) students observe a step-by-step exam on both a male and female model patient, then have the opportunity to prepare the exam room and perform at least one full STD exam (including specimen collection) on both a male and a female model patient in the presence of a preceptor. This course is designed for clinicians new to the STD practice setting. The course dates are August 16 and 17, 2004, and the fee for the course is $250. Contact Ronnie Staats at (206)-685-9848 or email: rstaats@u.washington.edu.

AUGUST 26, 2004

BASIC STD LAB SKILLS

This **1-day workshop** focuses on the **handling, performance, and interpretation of basic lab tests,** including wet mount and Gram stain, used in the diagnosis of various STD-related syndromes such as vaginitis and urethritis. Instruction is provided through a combination of lecture, class discussion, and hands-on microscopy practice. It is designed for the laboratorian or health care provider new to microscopy or in need of review of basic techniques. The course is held at the Washington State Public Health Laboratory, Seattle, WA. The course date is August 26 and the fee for this course is $150. Contact Ronnie Staats at the Seattle STD/HIV PTC for more information. Contact Ronnie Staats at (206)-685-9848 or e-mail: rstaats@u.washington.edu.

AUGUST 27, 2004

VENIPUNCTURE TECHNIQUES

This **1-day course** instructs students in the **basics of blood draw technique,** including tourniquet tying, finding and preparing a suitable vein, appropriate blood tube use, proper materials disposal and safety issues. The class is taught through lecture and hands-on practice on both simulated models and other course participants (not mandatory), and is designed for health care workers serving high-risk populations. The course is held at the Washington State Public Health Laboratory, Seattle, WA. The course date is August 27 and the fee for this course is $150. Contact Ronnie Staats at the Seattle STD/HIV PTC for more information. Telephone (206)-685-9848 or e-mail: rstaats@u.washington.edu.

AUGUST 31, 2004

The Governor's Advisory Council on HIV/AIDS (GACHA) meets from 9:00 A.M. to 3:00 P.M., August 31, at the Red Lion Hotel, Seattle Airport, in the Cascade Room. For additional information, go to http://www.doh.wa.gov/cfh/HIV_AIDS/GACHA/Default.htm, or contact Lynn Johnigk at (360) 236-3444 or e-mail her at: Lynn.Johnigk@doh.wa.gov.

AIDS WALK 2004

SEPTEMBER 25, 2004

Pierce County AIDS Foundation (PCAF) steps out on their **13th annual AIDS Walk,** with an exciting new walk route planned through the lively downtown area of Tacoma, incorporating the waterway, museums, the University of Washington, Tacoma, and the new convention center. Come participate in the AIDS Walk and Festival on Saturday, September 25. Contact Rus Batten for more information at 253-383-2565.

SEPTEMBER 26, 2004

Join **Lifelong AIDS Alliance** (LLAA) and friends, family and neighbors on September 26th at Seattle Center for the **18th Annual AIDS Walk!** Registration is convenient online- begin collecting your sponsorships today, or choose to be a sponsor. LLAA serves over 2,300 people needing services every year. Help is needed now as much as ever. Visit: http://www.lifelongaidsalliance.org/

Multifaith Works joins Lifelong AIDS Alliance on September 26, for the AIDS Walk. The AIDS Walk is the largest community AIDS event in the Pacific Northwest, coordinated by the Lifelong AIDS Alliance. Every September, thousands of supporters fill the streets of Seattle to raise money to help people living with HIV/AIDS and raise awareness about the epidemic. Sixty-five percent of the funds raised by Multifaith Works AIDS Walk registrants will benefit Multifaith Works programs. For further information, please contact Beth at (206)-324-1520 x221 or email beth@multifaith.org.

United Communities Against AIDS Network (UCAN) launches their **AIDS Walk** from Tumwater Historical Park this year. Sign-up starts at 10 a.m., and the walk begins at 11 a.m. Organize a walk team or be the cheerleader in your company or group. Be the one to make a difference in the fight against AIDS. Telephone (360)-352-2375, or email: http://www.ucan-wa.org/.

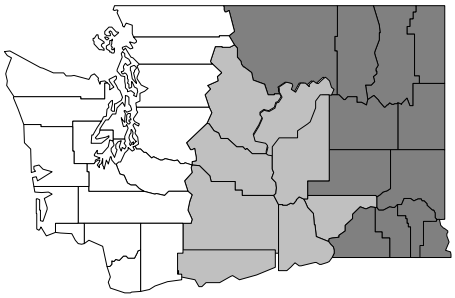
OCTOBER 21, 2004

The eighth annual **United States Conference on AIDS** (USCA) will take place October 21 through 24, 2004, at the Philadelphia Marriott Hotel in Philadelphia, Pennsylvania. In the past, there have been more than 3,000 service providers, people living with HIV/AIDS, policymakers, public officials, funders and other leaders attending USCA. The mission of the United States Conference on AIDS is to increase the strength and diversity of the community-based response to the AIDS epidemic through education, training, new partnerships, collaboration and networking.

OCTOBER 23, 2004

SHANTI VOLUNTEER TRAINING: October 23, 24 and November 6, 7. Shanti volunteers provide one-to-one, nonjudgmental support to people living with HIV/AIDS, cancer, MS, and other life-threatening illnesses. The Shanti training and volunteer experience has been described as life-changing for many volunteers. For more information, please call 206-324-1520 x3 or email shanti@multifaith.org.

Regions 1 & 2



Region One (dark area) includes Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman Counties. The Region One AIDSNET Office is in Spokane and the Coordinator is Barry Hilt at (509) 324-1551.

Region Two (gray area) includes Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat and Yakima Counties. The Region Two AIDSNET office is in Yakima and the Coordinator is Wendy Doescher at (509) 249-6503.

Transitions

Margarete Haas, AIDS Counselor/ Educator with the **Spokane Regional Health District** (SRHD) for nearly 18 years, has accepted another position within SRHD's Environmental Health Division. Margarete's wonderful dedication and counseling skills, her participation as a state trainer for the CDC HIV Prevention courses, and her commitment to providing HIV testing for the community has been invaluable. The SRHD HIV/AIDS program staff wish Margarete well in her new endeavors.

Spokane AIDS Network's (SAN) **Terry Davis** recently left his position as Positive Power Coordinator. SAN has been fortunate to have this talented and compassionate individual on the team for the last four years and staff wish him the best for his future endeavors. Also, **Tracy Mikesell** will be leaving her post as Director of Services in mid-July. Tracy has been employed with SAN for over 10 years. She is moving with her family to Seattle this summer.

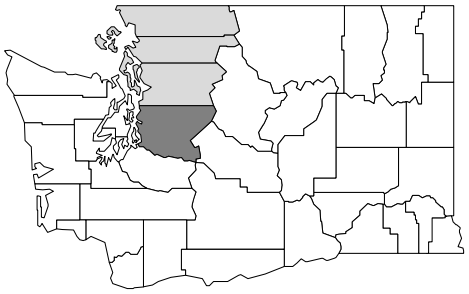
The **Yakima People Of Color Against AIDS Network** (POCAAN) office welcomes **Tina Corbin** as a new staff person. Tina will be working as the Native American outreach worker on the **Teaching Addicts Risk Reduction** (TARR) project. POCAAN is pleased and excited to welcome Tina to the POCAAN family. Also, acknowledgements go to **Jeanette Vargas**, who has volunteered her time in the TARR project from its birth. She is a very important player in this intervention. POCAAN is lucky to have these two great women involved!

Announcements

Spokane AIDS Network's HIV Treatment Adherence Program, **Body Wise**, recently received a Grant from the Paul Allen Foundation to provide treatment adherence in rural Region 1, outside of Spokane County. Program coordinator **Heidi Kriz, RN**, will provide treatment adherence counseling, no cost antioxidants and supplements, and body composition analysis to HIV case managed individuals residing in Region 1. The program also offers ongoing treatment adherence support and education for HIV case managers. For more information or to inquire about participation please contact Heidi at 509-455-8993 or email heidik@san-nw.org.

POCAAN's Teaching Addicts Risk Reduction (TARR) is in the 3rd year of operation. It has been a very successful project in Yakima. Last year 16 TARR groups were held, consisting of 64 sessions being conducted with active injection users. Over 120 active IDUs entered the project. This year, the TARR groups will be partially conducted in Region 2 by **Tina Corbin**. POCAAN is excited to bring TARR to six other counties to help local health departments build relationships with their injection drug user communities.

Regions 3 & 4



Region 3 (gray area) includes Island, San Juan, Skagit, Snohomish and Whatcom Counties. The Region 3 AIDSNET office is in Everett and the Coordinator is Alex Whitehouse at (425) 339-5211.

Region 4 (dark area) is King County. The Region 4 AIDSNET office is in Seattle and the Coordinator is Karen Hartfield, who can be reached at (206) 205-8056.

Transitions

Public Health - Seattle & King County's John Wiesman, Prevention Division Manager, has accepted the position of Health Department Director with Clark County Health Department. He has made significant contributions both through his leadership in Prevention, as well as the development of the Strategic Planning and Bioterrorism Planning processes. **Kari Tamura** will serve as the Interim Prevention Division Manager. Kari is currently the Assistant Division Manager. She is knowledgeable about the program and has excellent leadership and communication skills.

Starting this September, **Dr. Hunter Handsfield** will be taking a professional leave of absence from the Directorship of the STD Program. He has accepted a position at the Centers for Disease Control (CDC) and will divide his time between Atlanta and Seattle. Dr. Handsfield has been the Director of the STD program for over 25 years and has provided strong leadership, as well as modeled excellence in local public health and academic partnerships. **Dr. Matthew Golden** has been appointed Acting Director of the STD Program. Matt has served as Medical Director of the STD Clinic since 2001 and, as Assistant Professor of Medicine, continues the tradition of Public Health's strong affiliation with the University of Washington.

Announcements

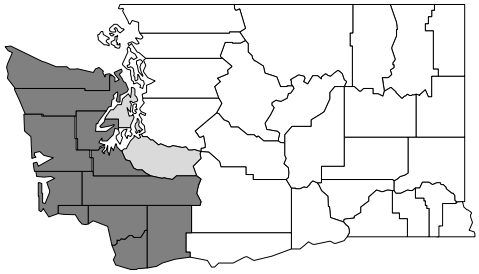
Frontline Hepatitis Awareness is a non-profit organization in Monroe, Washington, working to raise awareness of Hepatitis B and C, as well as co-infection with the HIV/AIDS virus. Frontline is involved in the education of patients and the public, and is planning a public education event in Snohomish County with speakers, testing opportunities, and a silent auction. Frontline also hosts an online group at http://frontline-hepatitis-awareness. com, and has a Toll Free number 1-866-Hep-GoGo (437-4646). Please call 360-425-1700 for more information.

Health Information Network continues to provide HIV/AIDS education for health and child care providers. The 4 to 7 hour HIV licensing course has recently been videotaped for the 6th time. The kit comes with a choice of VHS tapes or DVDs as well as printed materials and a brochure sampler with selected brochures from various HIV and STD warehouses. Ordering information is available by either calling 206-784-5655 or visiting http://www.healthinfonetwork.org./.

The **MSM HIV/STD Taskforce** is a coalition of community individuals, leaders and service providers dedicated to supporting and addressing the prevention and health needs of gay and bisexual men in Seattle King County. The Taskforce is open to all interested individuals. Members have various backgrounds and community experiences in gay and bisexual men's health issues. MSM HIV/STD Taskforce meetings are held on the first Monday

of every month from 6 to 8 p.m. at the LGBT Community Center at 1115 East Pike Street, Seattle, Washington, 98122. For further information contact Quinten Welch at 206-205-8671 or email: Quinten.Welch@metrokc.gov.

Regions 5 & 6



Region 5 (gray area) includes Kitsap and Pierce Counties. The Region 5 AIDSNET office is in Tacoma and the Coordinator is Mary Saffold at (253) 798-4791.

Region 6 (dark area) includes Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties. The Region 6 AIDSNET office is in Vancouver and the coordinator is David Heal at (360) 397-8086.

Transitions

Kitsap County Health District is pleased to announce that **Ricki Johnson** is the new **Program Manager** for Infectious Disease Prevention and Care Services. Ricki has extensive experience in a variety of HIV/AIDS prevention and care services in California and Washington. She can be reached at (360) 337-5261 or johnsr@health.co.kitsap.wa.us.

Pierce County AIDS Foundation (PCAF) has a new Development Officer, **Rus Batten.** Formerly of the Broadway Center for Performing Arts and a graduate of Evergreen State College, Rus will be taking on the special events and private giving campaign.

Tacoma-Pierce County Health Department (TPCHD) has been busy the last few months finalizing the integration of the DIS and HIV staff. This has proven to be a complementary component for both programs. **Carol Marsden** will be entering nursing school soon and the energy and passion that she brings to work everyday shall be missed. Carol has done a wonderful job as Prevention Case Manager. TPCHD is pleased to announce that **Kim Desmarais** accepted the position of Case Manager. Kim has been a DIS with TPCHD for one year and brings with her a wealth of experience in HIV and STD work.

Many changes have occurred recently at the **Clark County Health Department. Kay Koontz,** Executive Director, and **Roxce Stavney,** Clinic Services Manager, have both retired after many years of service. In addition, **Dr. Karen Steingart** has resigned her position as Health Officer. In the future, she intends to continue the work of helping create a healthier and more harmonious world. Good-bye and best wishes to all, and good luck in future endeavors!

John Wiesman will be taking the position of Executive Director of the Clark County Health Department effective July 19th. John comes to CCHD from his former position as the Prevention Division Manager at Public Health- Seattle & King County, where his significant leadership and development contributions were recognized. Welcome aboard, John!

Announcements

The Tacoma-Pierce County Health Department (TPCHD) has shifted the focus of their HIV Program. The new focus is helping clients and providers with ongoing Partner Counseling and Referral Services and client support. Clients seeking more intensive prevention counseling services such as Prevention Case Management (PCM) are being referred to the Pierce County AIDS Foundation as TPCHD no longer offers Prevention Case

Management Services. The goal of TPCHD is continues to work closely with HIV positive persons as well as providers, case managers, and other professionals around PCRS issues.

TPCHD started **HIV Rapid Testing** on April 13, 2004. Current rapid testing hours are on a walk-in basis Tuesdays 8:30 am-12:00 pm and again from 1:30 pm to 4:00 pm. As the word spreads, the number of people asking for this service increases. TPCHD has found that rapid testing is a popular option and especially helpful for persons notified that they may have been exposed to the HIV virus.

STATEWIDE

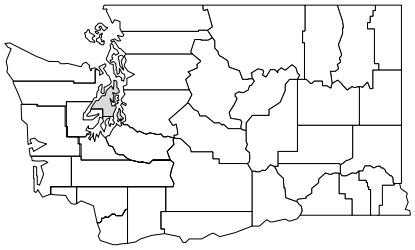
ANNOUNCEMENTS

John Peppert received the governor's nomination for the **2004 Governor's Distinguished Management Leadership Award.** John was nominated for his 20 years of remarkable dedication and exemplary work in a challenging field. He manages the Washington Department of Health HIV/AIDS Prevention and Education program, where he balances public health priorities with due process and individual rights. His success in finding that balance is demonstrated by his influence in creating the HIV/AIDS Omnibus Act, work in HIV reporting, and prenatal HIV testing. John is a proven public health leader who models excellence in management and builds strong, respectful relationships with staff, agency leadership, peers, stakeholders, and HIV/AIDS advocates.

VOLUNTEER OPPORTUNITIES

There are three **Adult Family Homes** in WA State that serve low-income **people living with HIV/AIDS: Three Cedars** (Tacoma), **Rosehedge** (Seattle), and the **Sean Humphrey House (**Bellingham). These homes provide housing and health care for those who can no longer care for themselves. The residents in these homes often have additional health issues, including histories ofsubstance use, mental illness, AIDS dementia and other illnesses.

These homes provide such things as three nutritious meals a day, help with bathing, grooming, ambulation and



laundry, and twenty-four hour a day care. Optional counseling and/or support groups are also available, as well as recreational activities. Most importantly the homes provide medication management for their residents. This is very significant because the regimen of prescribed pills can be very confusing and overwhelming while at the same time adherence to treatment is crucial to the health of the individual. The surroundings are clean and beautiful, fostering a sense of pride and well-being. The homes link the residents to the community by providing transportation, and through volunteers who offer opportunities to get out and do things in the community together. By empowering the residents with all these things, some of them become stabilized and can re-join the community if they choose. If you would like to **make a donation or volunteer** at a home near you, or if you would like information on upcoming events please call Sarah at 360-733-5543.

DOH TO ASSESS THE HIV PREVENTION NEEDS OF HIV INFECTED INDIVIDUALS

In April 2003, the Centers for Disease Control and Prevention (CDC) announced a new initiative entitled "Advancing HIV Prevention: New Strategies for a Changing Epidemic". The new initiative includes the following four strategies:

- Make HIV testing a routine part of medical care
- Implement new models for diagnosing HIV infection outside medical settings

- Prevent new infections by working with persons diagnosed with HIV and their partners
- Further decrease perinatal HIV transmission

Through the Advancing HIV Prevention initiative, the CDC is placing more emphasis on HIV counseling, testing, and referral for the estimated 180,000 to 280,000 Americans who are unaware of their HIV infection. The CDC is also emphasizing partner counseling and referral services, and prevention services for persons living with HIV to help prevent further transmission.

Also in 2003, the CDC issued revised guidance to the states for conducting the CDC-mandated HIV Prevention Community Planning process. In order to make the planning process consistent with the strategic direction of the Advancing HIV Prevention initiative, all HIV Prevention Community Planning jurisdictions throughout the country are required to prioritize HIV infected individuals as the highest priority population for appropriate prevention services. Up to nine additional populations considered to be "most at risk" for HIV infection can be listed as priorities within each jurisdicton's plan, but HIV infected individuals must be the number one priority.

HIV Prevention Community Planning groups are required to gather information on the HIV prevention needs of priority populations within their jurisdiction and to identify gaps in services to address those needs. Given that HIV infected individuals are now the number one priority population for Washington's seven HIV Prevention Community Planning Groups, Department of Health will be conducting an HIV prevention needs assessment with the infected community this Fall.

DOH plans to interview approximately 100 persons living with HIV in medium-sized counties before the end of 2004. The counties included in the needs assessment will be Spokane, Yakima, Pierce, Clark, and Snohomish. Participants will be recruited from a variety of settings (e.g., HIV service providers) within each area. All interviews will be conducted anonymously, and participants will be provided a small incentive to thank them for their time.

The survey tool for the intervention was developed in conjunction with the State Planning Group and is designed to assist planning groups to determine: 1) what can be done to reduce barriers that prevent HIV infected individuals from accessing HIV prevention services, and 2) what are the best methods and sources of HIV prevention information for HIV infected persons.

John Valliant will be the main interviewer for this needs assessment process. John has conducted interviews for the HIV Testing Survey (HITS) and Supplement to HIV/AIDS Surveillance (SHAS) throughout Washington. For additional information on the Needs Assessment for HIV Infected Individuals, contact Amy Manchester Harris at (360) 236-3417.

Please watch for more information concerning the Needs Assessment for HIV Infected Individuals this Fall. We are hopeful that information from this assessment will enable prevention programs to better address the prevention needs of HIV infected individuals and ultimately assist in the reduction of new HIV infections in Washington State.

State Planning Group

The State Planning Group (SPG) is scheduled to meet the 4th Thursday of the month from 9:30 A. M. to 3:15 P.M. Dates for the August through October SPG meetings are August 26, September 23 and October 28, 2004. The meetings are held in SeaTac. For specific meeting locations and topics, contact Harla Eichenberger at: (360) 236-3424 or visit: http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/HIV_Community_Planning.htm.

Community Planning

The six **AIDSNET Regions** continue to coordinate the local planning process through meetings of the Regional Planning Groups (RPGs). This process absolutely requires input and participation from members of the community infected and affected by this epidemic. Are you willing to become one of the voices that support effective prevention efforts? If so, please contact your local Regional Coordinator or DOH contact in the list below, for more information.

Barry Hilt - Region 1 AIDSNET (Spokane) – (509) 324-1551

Wendy Doescher – Region 2 AIDSNET (Yakima) – (509) 249-6503

Alex Whitehouse – Region 3 AIDSNET (Everett) – (425) 339-5211

Karen Hartfield – Region 4 AIDSNET (Seattle) – (206) 296-4649

Mary Saffold – Region 5 AIDSNET (Tacoma) – (253) 798-4791

David Heal – Region 6 AIDSNET (Vancouver) – (360) 397-8086

Brown McDonald – State Planning Group (SPG) – (360) 236-3421

HIV Prevention Focus

Interventions that Work

By Frank E. Hayes; DOH HIV Prevention and Education Services

In accordance with the CDC HIV Prevention Planning Guidance released last year, the state health department has the responsibility to identify, through the use of epidemiologic data, up to 10 populations at high risk for acquiring HIV. The Community Planning Group (CPG) has the responsibility of prioritizing those populations, placing HIV infected persons as the first/highest priority. The CPG is also responsible for identifying scientifically proven effective interventions for each of the prioritized populations that will assist in changing their risky behavior. In Washington State, communities are composed of varied sizes. Working in the varied communities to prevent the spread of HIV is not an easy task. You also know Agency collaboration is a good idea because it brings strength to any HIV prevention program; additionally, it may have a positive impact on the outcome of prevention efforts. Regardless whether HIV prevention activities are conducted in an urban or rural area, there is one extremely important agency that exists in all areas, a religious institution.

In virtually every community there is a church, synagogue, mosque or other religious institution that influences the lives of the community members. High-risk populations in need of HIV prevention messages live in these communities, may be a member of a congregation, or may know someone who attends the religious establishment and could receive HIV prevention messages from them (secondary prevention). The faith community is tremendously important in the battle against HIV and can assist greatly in: disseminating HIV prevention messages to the community; de-stigmatizing HIV; and, providing support for those who are infected and affected by HIV.

You may be asking yourself, "*Is it really possible for the church to have such an impact?*" The answer is a resounding **yes.** As proof of the power of a minister and a church, you might want to recall the civil rights movement of the early 60's when a little known minister, Reverend Martin Luther King, Jr., spearheaded the movement. The work he initiated not only assisted the African American community to bring about change- it also demonstrated to other downtrodden populations that *it is possible* to bring about necessary changes. Ministers are trusted and credible persons within the community; in communities of color, they may be held in even higher regard. As a trusted, knowledgeable, caring, and valued member of the community, ministers can bring about change in ways that may be more difficult for others to accomplish.

Your next question may be, "*If the church is so powerful, why haven't we tapped this resource?*" Getting into this arena may prove to be a very challenging endeavor; however, the faith-based community is not impervious. In the past, there has been some success in reaching the clergy. After reading several articles and visiting websites, I was able to identity some of the barriers that may be keeping HIV prevention efforts from reaching church members. To sum up some of the major barriers, I will use the acronym **kost. K =** knowledge – there may be a lack of knowledge by the ministers and their church staff. HIV prevention is not usually a part of a church's mission; therefore, the church may lack the ability and expertise to provide necessary HIV prevention services. **O** = opposition – the church may not be accepting of the lifestyles, which may lead to a person acquiring HIV. Talking about condoms may be viewed as condoning premarital sex. In some religious communities, condom use and premarital sex are totally unacceptable. Church leaders may only feel comfortable talking about abstinence. I imagine you are also aware the church may not be accepting of an injection drug user, a gay or bisexual man, and/or a person who engages in sexual activities with multiple partners. **S** = stigma – HIV has been and will remain a major concern in

the church until church leaders understand the disease. People who have HIV are often stigmatized, and some ministers are concerned that their church might be viewed as "the HIV/AIDS church". **T** = trust – some ministers are not sure HIV prevention agencies really have their parishioner's best interest at heart. There are concerns that once prevention programs are initiated, funding ends and so does the ability to continue HIV prevention activities. When this happens, the hopes of the individuals participating in HIV prevention programs are abruptly ended.

The next logical question is, "*How do we get into the faith community?"* The answer is very simple, "*We must remove the kost."* However, the process is challenging. Reducing the fear of HIV must be accomplished through education; fear of the unknown is exceptionally monumental, but it can be conquered. Teaching and involving church leaders in HIV prevention education would be a powerful tool in reducing fear, which in turn may remove the barrier of discussing HIV in the church. When I say church leaders, I am not only speaking about the ministers. As with any other organization or group, there are many influential people in the faith community who may be recruited to assist in getting HIV prevention activities initiated. Getting the church to change their opposition to an individual's lifestyle may be an unrealistic goal; approaching a minister with that intention may lead to a brick wall or the doors remaining closed. However, approaching church leaders in a manner that emphasizes this battle is not about accepting a person's lifestyle, but about the health of their community may result in a more favorable/desirable outcome. Having a respected pillar of the community talk about HIV would be particularly instrumental in reducing the stigma of the disease. As the Shepherd of their flock, hearing a minister say those seven letters (HIV/AIDS) may make it much easier for those infected/affected to feel at ease in discussing HIV. The actions we take in recruiting and talking with faith based community leaders will eventually increase the trust they place in HIV prevention efforts. We must show honesty, sincerity, desire, and compassion in our effort to battle this disease with every resource we have available.

Assisting ministers to join this effort is very advantageous. The Ark of Refuge, Inc. has produced a guidebook for ministers titled "*Healing Begins Here: A Pastor's Guidebook for HIV/AIDS Ministry Through the Church".* The guide contains accurate clinical data and assists clergy to: develop sermons; incorporate HIV/AIDS education strategies into their ministries; raise awareness and initiate dialog about HIV; and, mobilize their congregations to work towards halting the spread of HIV. The web address to download the guide is http://www.arkofrefuge.org/guidebook.html. The Balm In Gilead is another organization providing resources to ministers. This site provides information concerning development of sermons, HIV/AIDS data, and other resources. The web address is http://www.balmingilead.org/resources/.

If we do not make an effort to remove the *kost,* the *cost* in lives and money will continue to increase. This is not intended to imply agencies are not already doing a good job of reaching out to high-risk populations. It is intended to emphasize there is an incredibly important element not involved in HIV prevention efforts that would be a valuable ally in this battle against HIV/AIDS.

Intervention in the Spotlight

Intervention Type: Group Level Intervention (with an outreach component) and an Individual-level Intervention

Risk Transmission Category: Injecting Drug and Crack Cocaine Users

Behavior Placing Them at Risk: Sharing needles and unprotected sex

Setting: Varies with the activity being conducted

Study Title: "*A Cognitive-behavioral Intervention to Reduce HIV Risk Among Active Drug Users. In Staying Negative in a Positive World: HIV Prevention Strategies That Work"* Fen Rhodes, PhD, Michele M. Woods, M.S., and Scott L. Hershberger, PhD (2000). Sacramento: California Department of Health Services, Office of AIDS.

Article Description:

The purpose of the study was to examine: 1) the efficacy of an intense theory-based intervention compared to a two-session intervention, and 2) the relationship between type of personal HIV risk reduction goal and magnitude of behavior change for drug use versus sex related risks. Several related scientifically based ideas were instrumental in the development of specific intervention activities likely to be successful in changing the HIV risk behaviors of active drug users. *The Transtheoretical Stage Model* – this model maintains behavior change occurs in five stages and movement through these stages varies from person to person. It is also important to remember people may be in different stages of change with different activities related to risky behaviors. *The Health Belief Model* – this model maintains health related behaviors depend on four key beliefs (perceived susceptibility, perceived severity, perceived benefits, and perceived barriers) that must be in operation for behavior to change. *Theory of Protective Motivation* – this theory maintains that a person conducts an appraisal in the areas of threat (severity, vulnerability, and rewards) and coping (response efficacy, self-efficacy, and response costs); changes in an individual's risky behavior depends on the results of the self appraisal. As you can see, the theory and two models used as the intervention's framework are very closely related.

This theory based cognitive behavioral intervention was conducted in Long Beach, California between 1992 and 1996. Indigenous outreach workers recruited participants during outreach activities and through chain referrals. Participation eligibility criteria included 1) self-report of injection or crack cocaine use in the past 30 days; 2) evidence of recent drug use from track marks and/or urine testing positive for opiates/cocaine; and, 3) participation in two sessions of standard HIV counseling with optional testing. Once recruited, the participants were assigned to study conditions based on their geographical recruitment area. A total of 1,237 out-of-treatment IDUs and crack users participated in a standard or enhanced intervention. They were also required to complete a baseline survey (Risk Behavior Assessment) prescribed by NIDA (National Institute on Drug Abuse) and provide a urine specimen that was tested for opiates and cocaine. Each participant received a $10 incentive for completing the baseline survey. Variables used in this tool were: gender, race/ethnicity, age, employment status, drug use, HIV status, homelessness, and time in jail during the past month. Interestingly enough, there were not significant differences between the standard group and the enhanced group.

The participants assigned to the standard group only received the standard NIDA intervention. This two-session intervention incorporated drug-focused prevention education, including HIV/AIDS information and optional HIV testing, as mandated by NIDA. Those assigned to the enhanced group received a more extensive intervention. Outreach and health education staff delivered structured and unstructured psycho-educational activities in both group and individual settings. The intervention consisted of: the two-session NIDA intervention; two interactive group workshops that employed stages of

change framework; a single one-on-one counseling session which focused on refining the client's risk reduction plan; a minimum of two field based follow-up visits with outreach workers; and, participation in a minimum of two social events to provide peer support for risk reduction. The nine-session intervention spanned a period of four to six months. Non-monetary incentives in the way of food bank services, food coupons, bus tokens, meals, and personal hygiene kits were provided to encourage continued participation.

The study protocol prescribed administering the follow-up interview 5 to 9 months after enrollment into the intervention. It also prescribed that there be at least 30 days between the most recent contact and the follow-up interview. During the follow-up interview, another urine specimen was collected and tested for opiates and cocaine. Participants in both the standard and enhanced intervention received $20 for completing the post intervention interview. Based on the post intervention interview, participants in the enhanced intervention were more than two and a half times more likely to increase condom use. Participants in the enhanced intervention were also more likely to: 1) reduce the number of times using injection drugs; 2) reduce the number of days injecting; 3) stop injecting completely; 4) have a follow-up urine test that was negative for opiates or cocaine; 5) stop using crack; and, 6) have entered or tried to enter drug treatment within six months prior to follow-up. Enhanced intervention participants experienced the greatest behavior change in behavioral areas congruent with the personal risk reduction goals they selected upon entry to the program. The researches found this to be significant for two reasons. First, it provided evidence emphasizing the importance of personal commitment for achieving meaningful behavior change. Second, it demonstrated the importance of tailoring behavioral interventions so that they address the needs of the participants. To me, this really boils down to meeting the clients where they are in their desire to change risky behavior.

For those who prioritized IDUs as one of the 10 most at risk populations, you may want to consider this intervention. The feedback received from a community needs assessment and this short synopsis of the intervention will assist you in determining if your population fits into this intervention. If your prioritized population fits this intervention, the intervention may be replicated. If there are differences, adaptation of the intervention may be necessary to meet your population's needs. To maintain fidelity and ensure effectiveness, you **must** remember to maintain the core elements. After reviewing the article, the *Guidance,* and visiting the website listed below, it is my opinion there are five-core elements:

1. **Recruitment for groups;**
2. **Two group sessions;**
3. **One individual counseling session;**
4. **Two (or more) group socials events; and,**
5. **Two (or more) follow-up contacts.**

The intervention in the spotlight this month offers you a unique opportunity to get additional information from three sources. The contact for the original article is: Fen Rhodes, CSULB Center for Behavioral Research and Services, 1090 Atlantic Avenue, Long Beach CA 90013. Telephone number: (562) 495 2330; fax number: (562) 983-1421; email is frhodes@csulb.edu. You may also review the *Guidance* released last year by CDC with the CBO program announcement. The site is: http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft_5.pdf.

In the *Guidance*, the intervention is called "*Safety Counts*". The final location to acquire information about the intervention is on the Sociometrics website. The address is **www.socio.com.** The intervention there is called "*Safety Point*". If you have questions or comments for me, I may be contacted by telephone at (360) 236-3486 or via email at frank.hayes@doh.wa.gov.

The STD Focus

BY BONNIE NICKLE; DOH STD EDUCATIONAL RESOURCE COORDINATOR

STD 101 for Outreach Workers:

What About Those Expensive Herpes Blood Tests?

Judging from calls to us here at the Washington state hotline at 1-800-272-2437, about half of the younger callers have an intellectual understanding that they can have herpes and have no symptoms. Unfortunately, the emotions that go along with this infection means that reversion to "but I'd know it if I had it, right?" is common. An outreach worker dealing with arguments or fears among herpes-infected and uninfected partners needs to know a little about testing for herpes and keep in mind that **no test is perfect.**

First of all the inexpensive culture test (be sure it is ordered "with typing") is available almost everywhere in Washington state. In order for the test to function optimally, very FRESH sores with lots of virus are needed. The value of this test goes way down after 72 hours and after the least hint of scab formation, since by that time the virus at the surface of the skin is dying. Pull strings to get your client into a clinic for a very brief visit within the **first 24 hours** when a client does have symptoms. Another test used for herpes sores, the PCR test, is expensive but much more sensitive. It may not be available in rural areas.

Many people are thrilled to discover that blood tests exist. Though not many of our callers own computers, it is not uncommon to have them say that they do use those available though the library system. They state that they have, indeed, found herpes education sites but cannot sort out the information. They have some idea that blood tests are available, but they have a difficult time finding out about costs.

The American Social Health Association's web site at http://www.ashastd.org/pdfs/blood_test.pdf has a list of herpes blood tests and their prices.

What can we do about clients with no money and no private insurance? Here's what Washington's DSHS staff says about clients on Medicaid: "Yes, both the blood tests and cultures are covered." (Tell the caseworker to look under herpes serologies.) "All three of the herpes antiviral medications are covered, too." The complete list of Washington state DSHS drugs is available at http://fortress.wa.gov/dshs/maa/pharmacy/. However, according to Jim Stevenson of DSHS there are **limits.** People in the TAKE CHARGE and FAMILY PLANNING ONLY programs are typically NOT eligible for the tests and the medications unless the tests and medications are directly related to the client's need for birth control. In the HEALTHY OPTIONS program, coverage is whatever is available through the HMO in which the client is enrolled. Outreach workers need to be in touch with experts who can help with navigating public insurance systems as clients go in and out of various public insurance programs. With chaotic clients, be sure to check expiration dates of various cards. People can become very frustrated if they are referred for services for which they are not eligible.

The good news about the herpes test is that the very best results for the blood tests come three to four months after infection. The blood tests measure antibodies to the herpes virus and it takes awhile to produce antibodies. That's at least three months to plan and save. Four months would be even better. At this time, if you want good type-specific antibody results you simply must wait.

A positive IgG type-specific antibody test means that a herpes infection (type 1, type2, or both) is present and can be spread to others. A single test does not necessarily indicate when the client became infected or where the virus first entered the body. Be sure that the new versions of tests are ordered. An IgG test with typing (for herpes type 1 and type 2) is most commonly offered now.

Seattle's herpes Western Blot is the research "Gold Standard." It is the test against which all other tests are measured. This is available in our state, but must be ordered by a clinician who should call the UW Herpes lab at (206) 526-2088. The test will be sent to a doctor's office, not a private home.

Got a client with symptoms of a first-time (primary) herpes infection and lots of money? S/he could have two blood tests, the first right away and the second much later. A negative first test and a positive second test might verify a new infection. But, be very careful here. Until all tests are complete (and no test is perfect), the outreach worker needs to explain that many symptomatic episodes of genital herpes actually represent old recurrent infections. A **new diagnosis** of genital herpes in a monogamous couple **is not always a new infection** from another partner.

In most of Washington state, there is no public funding for herpes serologies (blood tests) for those not eligible for the Medicaid or HMO programs mentioned above. The exception is King County where residents may be eligible for herpes research projects. Free herpes testing could be part of the deal. The Seattle Weekly, a free newspaper, advertises for participants for herpes research and the University of Washington's herpes lab web site at http://depts.washington.edu/herpes/ has explanations for the kinds of people (infected, uninfected, one partner infected, one not, HIV+ or -, etc.) wanted for current research.

Do we want to have herpes blood tests available for all high- risk clients?

You bet. Seventy to eighty percent of those who are infected don't know it. If informed of their infection, they could alert partners and learn about prevention options.

Selected Readings

How to Read the References

Author(s), "Title," *Journal Name*, Date or Year; Volume (Number): Pages.

Key:

* Popular Reading
** Moderate Difficulty; Some Understanding Of Medical Terms
*** Medical Background Needed
**** Technical Reading.

If you cannot access library services, please contact Bonnie Nickle at (360) 236-3460 for single copies of these articles.

**** Muir A.J., Bornstein J.D. and Killenberg P.G. "Peginterferon Alfa-2b and Ribavirin for the Treatment of chronic Hepatitis C in Blacks and Non-Hispanic Whites." *New England Journal of Medicine. May 27, 2004*;350(22):2265-2271. The researchers state that black patients have a lower response rate that is not explained by differences in the viral genotype.

*** Blendis L., Lurie Y. and Oren R. "Treatment of Chronic HCV -- Should We Stop Treating Non-responders?" *Gastroenterology.* May 2004;126(5):1485-1487.

*** U.S. Preventive Services Task Force. "Screening for Hepatitis C Virus Infection in Adults: Recommendation Statement." Evidence-based review. *Annals of Internal Medicine.* March 16, 2004;140(6):462-464. http://www.annals.org/cgi/content/full/140/6/462

** Ward R.P., Kugelmas M. and Libsch K.D. "Management of Hepatitis C: Evaluating Suitability for Drug Therapy." *American Family Physician.* March 15, 2004;69(6):1429-1439. Includes patient education materials.

*** Ginès P., Cárdenas A., Arroyo V. and others. "Management of Cirrhosis and Ascites." *New England Journal of Medicine.* April 15, 2004;350(1 6):1646-1654. Review article.

*** Lavanchy D. "Hepatitis B Virus Epidemiology, Disease Burden, Treatment and Current and Emerging Prevention and Control Measures." *Journal of Viral Hepatitis.* March 2004:11(2):97-107.

*** Sonnenberg F.A., Burkman R.T., Hagerty C.G. and others. "Costs and Net Health Effects of Contraceptive Methods." *Contraception.* June 2004;69(6):447-459. Includes chart of annual probability of pregnancy by method and age, cost of medical events and complications (premature newborn: $31,196.00), and contraceptive method costs.

** Wright T.C., Schiffman M., Solomon D. and others. "Interim Guidance for the Use of Human Papillomavirus DNA Testing as an Adjunct to Cervical Cytology for Screening." *Obstetrics and Gynecology.* 2004;103:304-309. NIH, ASCCP, and ACS workshop conclusions – DNA testing may be added for screening of women over 30; those negative for both tests need not be re-screened for 3 years. Outlines situations where tests should not be used, such as women aged less than 30 years or immunocompromised women," wrote Dr. Christopher M. Zahn in an editorial in the same issue.

*** Anderson M.R., Klink K. and Cohrssen A. "Evaluation of Vaginal Complaints." *JAMA.* March 17, 2004;1368-1379.

** Deneux-Tharaux C., Kahn E. and Nazerali H. "Pregnancy Rates After Vasectomy: A Survey of US Urologists." *Contraception.* May 2004;69(5):401-406. 51% of pregnancies occurred during the immediate post-vasectomy period. About 1 pregnancy per 1000 vasectomies occurred. The rate was less for surgeons who performed more than 50 procedures per year.

* Brody J. "Abstinence-Only: Does It Work?" *New York Times, Science Times.* Tuesday, June 1, 2004:D7.

** Eisenberg M.E., Bearinger L.H., Sieving R.E. and others. "Parents' Beliefs About Condoms and Oral Contraceptives: Are They Medically Accurate?" *Perspectives on Sexual and Reproductive Health.* March/April 2004;36(2):50-57. Educators encouraging parents to talk with their teens should provide parents with medically accurate information.

** Steinbrook R. "Waiting for Plan B --- The FDA and Nonprescription Use of Emergency Contraception." *New England Journal of Medicine.* June 3, 2004;350(23): 2327-2329.

*** Gonzales G.F., Muñoz G., Sánchez R. and others. "Update on the Impact of *Chlamydia trachomatis* Infection on Male Fertility." *Andrologia.* February 2004;36(1):1-23.

* Stewart F.H., Shields W.C. and Hwang A.C. "Faulty Assumptions, Harmful Consequences: Coming to Terms with Adolescent Sexuality." *Contraception.* May 2004;69(5):345-346.

*** Burstein G.R., Lowry R., Klein J.D. and others. "Missed Opportunities for Sexually Transmitted Diseases, Human Immunodeficiency Virus, and Pregnancy Prevention Services During Adolescent Health Supervision Visits." *Pediatrics.* May 5, 2003;111(5):996-1001.

*** Rylander E., Berglund A-L. and Krassny C. "Vulvovaginal Candida in a Young Sexually Active Population: Prevalence and Association with Oro-Genital Sex and Frequent Pain at Intercourse." *Sexually Transmitted Infections.* 2004;80:54-57. Karolinska study of 219 patients.

*** Idahl A., Boman J. and Kumlin U. "Demonstration of *Chlamydia trachomatis* IgG Antibodies in the Male Partner of the Infertile Couple is Correlated with a Reduced Likelihood of Achieving Pregnancy." *Human Reproduction.* May 2004;19 (5):1121-1126.

**** Larsson P-G, Carlsson B., Fåhraeus L. and others. "Diagnosis of Bacterial Vaginosis: Need for Validation of Microscopic Image Area Used for Scoring Bacterial Morphotypes." *Sexually Transmitted Infections.* 2004;80:63-67.

** Boonstra H. "Comprehensive Approach Needed To Combat Sexually Transmitted Infections Among Youth." *The Guttmacher Report on Public Policy.* March 2004;7(1): 3-4, 13.

** Coyle K.K., Kirby D.D., Marin B.V. and others. "Draw the Line/Respect the Line: A Randomized Trial of a Middle School Intervention to Reduce Sexual Risk Behaviors." *American Journal of Public Health.* May 2004;94(5):843-851. The intervention delayed sexual initiation among boys, but not girls.

** Shafii T., Stovel K., Davis R. and Holmes K. "Is Condom Use Habit Forming?" *Sexually Transmitted Diseases.* June 2004;31(6):366-372. Among adolescents, early condom use is associated with increased likelihood of subsequent condom use.

*** Marrazzo J.M. and Stine K. "Reproductive Health History of Lesbians: Implications for Care." *American Journal of Obstetrics and Gynecology.* May 2004;190(5):1298-1304. Previous pregnancy, induced abortion, and hormonal contraceptive use were reported commonly in a study of 392 women who reported sex with other women, regardless of self-identifications as lesbian.

*** Parkes R., Renton A. and Mehuus A. "Review of Current Evidence and Comparison of Guidelines for Effective Syphilis Treatment in Europe." *International Journal of STD and AIDS*. February 2004;15:73-88. Interesting material for those dealing with immigrants or international public health issues – explanation of necessity for high serum levels of PCN, treatment of contacts, pregnancy and congenital syphilis. Russian protocols are included.

*** Weaver B.A., Feng Q., Holmes K.K. and others. "Evaluation of Genital Sites and Sampling Techniques for Detection of Human Papillomavirus DNA in Men." *Journal of Infectious Diseases.* February 16, 2004;189:677-685.

*** Kaydos-Daniels S.C., Miller W.C., Hoffman I. and others. "The Use of Specimens from Various Genitourinary Sites in Men to Detect *Trichomonas Vaginalis Infection." Journal of Infectious Diseases.* May 15, 2004;189 (10):1926-1931. Semen was the most sensitive and in 25.6% of cases, only semen specimens tested positive.

** Miller W.C., Ford C.A., Morris M. and others. "Prevalence of Chlamydial and Gonococcal Infections Among Young Adults in the United States." *Journal of the American Medical Association.* May 12, 2004;291(18):2229-2236.

** Holmes K.K., Levine R. and Weaver M. "Effectiveness of Condoms in Preventing Sexually Transmitted Infections." *Public Health Reviews.* June 2004;82(6):454-461. Important review of research.

**** Hogewonning C.J.A., Bleeker M.C.G., van den Brule A.J.C. and others. "Condom Use Promotes Regression of Cervical Intraepithelial Neoplasia and Clearance of Human Papillomavirus: A Randomized Clinical Trial." *International Journal of Cancer.* December 10, 2003;107(5):811-816.

**** Bleeker M.C.G., Hogewonning C.J.A., Voorhorst F.J. and others. "Condom Use Promotes Regression of Human Papillomavirus-Associated Penile Lesions in Male Sexual Partners of Women With Cervical Intraepithelial Neoplasia." *International Journal of Cancer.* December 10, 2003;107(5):804-810.

*** Shrier L.A., Dean D., Klein E. and others. "Limitations of Screening Tests for the Detection of *Chlamydia trachomatis* in Asymptomatic Adolescent and Young Adult Women." *American Journal of Obstetrics and Gynecology.*

*** Kimberlin D.W. and Rouse D.J. "Genital Herpes." *New England Journal of Medicine.* May 6, 2004;350(19):1970-1977.

*** Newman L.M., Wang S.A., Ohye R.G. and others. "The Epidemiology of Fluoroquinolone-Resistant *Neisseria gonorrhoeae* in Hawaii, 2001." *Clinical Infectious Diseases.* March 1, 2004;38(5):649-654. There was a 17% rate of resistance.

* Delbanco F. "The Sexual Disease Up To 75% of Young Women Will Get." *Glamour Magazine.* May 2004:110-113. Do your clients read this publication? Overview of HPV from a source they trust and enjoy.

** Gold R.S. "Explaining Gay Men's Unrealistic Optimism About Becoming Infected With HIV." *International Journal of STD and AIDS*. February 2004;152: 99-102. Self-justification, anxiety reduction, and cognitive strategies in an Australian study of 122 males recruited in a Melbourne gay bar.

** Blackard J.T. and Mayer K.H. "HIV Superinfection in the Era of Increased Sexual Risk-Taking." *Sexually Transmitted Diseases.* April 2004;31(4):201-204.

**** "Directly Observed Therapy and Other Community-Based Efforts to Improve Adherence to HAART." *Clinical Infectious Diseases.* June 1, 2004;38 Supplement 5;S373-S436. The entire supplement is devoted to adherence issues.

*** Pilcher C.D., Tien H.C., Eron J.J and others for the Quest Study. "Brief but Efficient: Acute HIV Infection and the Sexual Transmission of HIV." *Journal of Infectious Diseases.* May 15,2004;189(10):1785-1792.

*** Perna A.G., Bell K. and Rosen T. "Localized Genital Norwegian Crusted Scabies in an AIDS Patient." *Sexually Transmitted Infections.* February *2004;80 (1):72-73.* Case report indicating that clinical appearance can vary dramatically, and burrows and pruritis may be absent or decreased.

**** Panther L.A., Wagner K., Proper J. and others. "High Resolution Anoscopy Findings for Men Who Have Sex with Men: Inaccuracy of Anal Cytology as a Predictor of Histologic High-Grade Anal Intraepithelial Neoplasia and the Impact of HIV Serostatus." *Clinical Infectious Diseases.* May 15, 2004;38(10):1490-1492. The authors compared biopsy or surgical excision with Pap smears as paired specimens for 153 men. Sensitivity and specificity and positive and negative predictive values are listed.

** Tun W., Gange S.J., Vlahov D. and others. "Increase in Sexual Risk Behavior Associated with Immunologic Response to Highly Active Antiretroviral Therapy among HIV-Infected Injection Drug Users." *Clinical Infectious Diseases.* April 15, 2004;38(8):1167-1176.

*** Himelstein B.P., Hilden J.M. Boldt A.M. and others. "Pediatric Palliative Care." *New England Journal of Medicine.* April 22, 2004;350(17):1752-1762. Review article.

** Rotheram-Borus M.J., Lester P. and Wang P-W. "Custody Plans Among Parents Living With Human Immunodeficiency Virus Infection." *Archives of Pediatrics and Adolescent Medicine.* April 2004;158(4);327-332. Substance use and ethnicity were unrelated to making custody plans in this study of 296 parents.

*** Stebbing J. Gazzard B. and Douek D.C. "Mechanisms of Disease: Where Does HIV Live?" *New England Journal of Medicine.* April 29, 2004;350(18):1872-1880. Review and update.

** Colfax G., Vittinghoff E., Husnick M.J. and others. "Substance Use and Sexual Risk: A Participant- and Episode-level Analysis among a Cohort of Men Who Have Sex with Men." *American Journal of Epidemiology.* May 15, 2004;159 (10):1002-1012. Seattle, San Francisco and other researchers looked at over 4,000 subjects. They call for an emphasis on substance use during sex for programs aimed at preventing HIV transmission.

** "Gabapentin (Neurontin) for Chronic Pain." *The Medical Letter.* April 12, 2004;46(1180):29-31. Brief review of a drug used for post-herpetic neuralgia and other neuropathic pain syndromes.

**** *Clinical Infectious Diseases.* March 1, 2004, 38 Supplement 2. Pages S43-S113. The entire supplement is devoted to hepatic safety and HAART.

** Knight D. "Health Care Screening for Men Who Have Sex with Men." *American Family Physician.* May 1, 2004;69 (9):2149-2156. Includes patient, provider and health care system obstacles to achieving good screening and communication. Easy-to-read article for clinical students and MSM patients who want better communicate with health care providers.

*** Thomas C.F. and Limper A.H. "Pneumosystis Pneumonia." *New England Journal of Medicine.* June 10, 2004;350 (24):2487-2498. Review article.

** Mandalakas A.M. "Tuberculosis Screening In Immigrant Children." *The Pediatric Infectious Disease Journal.* January 2004; 23(1):71-72.

** Smith H. "The Strange Case of Mr. Keat's Tuberculosis." *Clinical Infectious Diseases.* April 1, 2004;38(7):991-991. Literary and medical speculations on TB and syphilis diagnoses for the 19th century physician and poet John Keats.

** Murray J.F. "Mycobacterium tuberculosis and the Cause of Consumption: From Discovery to Fact." *American Journal of Respiratory and Critical Care Medicine.* May 15, 2004; 169(10):1086-1088. History of medicine essay – TB, arguments and egos.

**** Jha A.K., Shojania K.G. and Saint S. "Forgotten but Not Gone." *New England Journal of Medicine.* June 3, 2004; 350 (23):2399-2404. Atypical presentation of TB.

**** Chan E.D., Laurel V. Strand, M.J. and others. "Treatment and Outcome Analysis of 205 Patients with Multidrug-resistant Tuberculosis." *American Journal of Respiratory Care and Critical Care Medicine.* May 15, 2004; 169(10):1103-1109. An analysis from National Jewish Medical and Research Center.

** Horsburgh C.R. "Priorities for the Treatment of Latent Tuberculosis Infection in the United States." *New England Journal of Medicine.* May 13, 2004;350(20):2060-2067. Includes charts of annual and lifetime risk of reactivation, medical conditions that impair immune control of TB, and recommendations for retesting.

*** Nettles R.E., Mazo D., Alwood K. and others. "Risk Factors for Relapse and Acquired Rifamycin Resistance after Directly Observed Tuberculosis Treatment: A comparison by HIV Serostatus and Rifamycin Use." *Clinical Infectious Diseases.* March 1, 2004;38(5):731-736.

Book Reviews

AIDS BOOK REVIEW JOURNAL, University of Illinois at Chicago; H. Robert Malinowsky, Editor.
http://www.uic.edu/depts/lib/aidsbkrv/No72.html#1198

African American Women and HIV/AIDS: Critical Responses
Edited by Dorie J. Gilbert, Ednita M. Wright. 2003. Praeger, 88 Post Road West, Westport, CT 06881.

"By the year 2005, African Americans are estimated to represent over 60 percent of all AIDS cases in the United States." This is the first book to focus strictly on African American women and AIDS. It highlights the life stories, relationship dynamics, challenges, and perseverance of African American women. This is the fastest growing group of HIV/AIDS infected individuals. In the first part of the book "the aim is to reconstruct the meaning of individual and group risks for HIV-infection, as this pertains to African American women." It tries to answer the question of why African American women are so over-represented among U. S. AIDS cases. The second part discusses the "individual and collective (family and community) concerns about and responses to the AIDS crisis among African Americans." Historically the Black churches have been the pillars of hope for the African American community. "But churches are now being challenged to rethink moral codes (specifically the teaching that homosexuality is a sin) that keep them, as an organized body, from leading the fight against AIDS." Part 3 "is devoted to our young women who face incredible challenges to a healthy coming of age in the midst of the AIDS crisis, which is already ravishing African American adolescents, especially those in poor, urban environments." This group of women is in need of a sensitive approach to prevention. The last part delves into public policy. It addresses the need for change and describes one Black-initiated agency that responds holistically to HIV prevention and intervention needs of Blacks. This book brings forth the issues that are confronting the Black communities throughout the United States.

Women's Experiences with HIV/AIDS: Mending Fractured Selves, by Desirée Ciambrone. 2003**.** Haworth Press, 10 Alice St., Binghamton, NY 13904-1580.

"To more fully understand women's experiences with HIV infection we must gain a better understanding of how, and to what extent, they restructure their everyday lives to manage and cope with their illness, as well as the obstacles to such reorganization." This book tells the stories of 37 women who are infected with HIV. It talks of their personal efforts in dealing with HIV, explaining what they have done- which may or may not have been successful. The book points out how important relational resources, such as AIDS activism, support groups, and social support, are in the day-to-day coping. Women with HIV/AIDS often face subjected many social issues including: socioeconomic status, sexual preference, and lifestyle differences. This would be an appropriate book for those who are in the fields of medical sociology, women's studies, public health, and community health.

Other Health Resources

HIV

Trail to Treatment is a guidebook for outreach workers, case managers, counselors and other frontline staff who refer adults to drug and alcohol treatment. It contains information on treatment and payment options, types of detox and youth treatment. Download a copy at: http://www.metrokc.gov/health/apu/#new.

A May 2004 Kaiser Family Foundation HIV/AIDS Policy Issue Brief on "Financing HIV/AIDS Care" provides updated information on average annual costs, per patient, for HIV medical care, as well as provides a comprehensive overview of the current financing system for HIV/AIDS care in the U.S. The report states: "Combination therapy alone costs between $10,000 and $12,000 per patient per year depending on the regimen and payer...When additional medical expenses for doctor's visits, laboratory tests, and drugs to prevent or treat HIV-related opportunistic infections are taken into account, average annual costs rise to approximately $18,000 to $20,000 per patient, with even higher expenses for those with more advanced illness. Visit http://www.kff.org/hivaids/1607-02.cfm.

Earlier this year, the US Centers for Disease Control and Prevention ranked the Baton Rouge metro area in a tie with Miami as second in the nation for new AIDS cases per capita with a rate of 49.5 cases per 100,000 people for 2002. The Baton Rouge Citizens Against HIV group developed a media campaign including billboards, television spots, radio ads, flyers, posters, and an information hotline. Visit the prevention website at: http://www.hivinbr.com/.

The Body features women and HIV in their current issue. *"Twenty years and 60 million infections later the world has yet to realize that HIV is not just a man's problem"*. Visit http://www.thebody.com/features/women/stories_jmcdonald.html. to read Elinor Nauen's article *AIDS: A Women's Disease,* and enjoy the profiles of three women and their inspirational personal stories of living with HIV.

Health educators and **HIV prevention planning groups** have an excellent resource for **effective interventions and strategies**, including: definitions of theories and models with their core elements; core elements of health education and risk reduction activities; the Centers for Disease Control's intervention checklist for HIV prevention programs; and, a resource page. Visit http://www.doh.wa.gov/cfh/hiv_aids/Prev_Edu/effective_interventions.htm.

The FDA's press release on approval of the rapid HIV antibody test, OraQuick is at http://WWW.FDA.gov/bbs/topics/news/2004/NEW01042.html. Reminder: this blood test has not been approved for screening of blood donors or for home use.

http://www.thebodypro.com/hepp/mar04/case_study.html?mb19t is the web address for Case Study: Drug-Drug Interactions Associated with the Use of Antiretroviral Therapy" by Bethany Weaver, D.O., M.P.H. This is a case study of an HIV/hepatitis C-coinfected patient with a complicated presentation.

Stigma against HIV-infected persons remains very much alive and well in the United States despite two decades of progress fighting the disease clinically and culturally. The U.S. Health Resources and Services Administration has compiled a report on the current state of HIV-related stigma in the U.S., and offers practical steps that healthcare providers can take to help eliminate stigma. Visit the website http://www.thebodypro.com/hrsa/stigma.html?mb19t.

A new Special Surveillance Report, Number 2: Supplement to HIV/AIDS Surveillance Project - Demographic and Behavioral Data from a Supplemental HIV/AIDS Behavioral Surveillance Project, 1997-2000, is at http://www.cdc.gov/hiv/stats/Surveillance-No%202_2.pdf.

STD Prevention, Family Planning and Reproductive Health

Authors King Holmes, Ruth Levine and Marcia Weaver have reviewed **condom effectiveness** studies. Their document, published by the Bulletin of the World Health Organization, is located at:www.who.int/entity/bulletin/volumes/82/6/en/454.pdf. The authors have researched prospective studies published after June 2000, as a follow up to the United States National Institutes of Health (NIH) June 2000 review of scientific evidence on effectiveness of condoms in preventing sexually transmitted infections. Research findings available since the NIH review add considerably to the evidence of the effectiveness of condoms against STIs. Although condoms are not 100% effective, partial protection can substantially reduce the spread of STIs within populations.

The Contraception Report for February 2004 includes: a one-credit category 1 CME offering from the AMA; an STD overview; a copper IUD overview; a body weight/OC question-and-answer session; an Oral Contraceptive side effects section; and, a review of male latex condoms. Visit the website at http://www.contraceptiononline.org/contrareport. Back issues include reviews of latex and non-latex condoms.

The CDC's STD education program, "STD 101 in a Box," a ready-to-use education program, has been **revised** to reflect asymptomatic infection. Versions for clinical and outreach workers are available at http://www2a.cdc.gov/STD101. You must register to gain access to this information.

Contraception in the United States: Current Use and Continuing Challenges http://www.agivsa.org/sections/index.html#presentation%20tools contraception-us.html is a PowerPoint presentation tool that brings together the most current information available on contraceptive use, contraceptive development and barriers to access in the United States.

For an article on "**Oral Sex Among Adolescents: Is It Sex Or Is It Abstinence**?" go to the men's resource site at http://www.menstuff.org/issues/byissue/oralsex.html

Schools and Community Based Organizations can benefit from an **emergency contraceptive** tool kit; go to http://www.aed.org/Health

www.ojp.usdoj.gov features a report, "**Juveniles in Corrections**," that includes age, race, gender and offenses of young people in both public and private placement facilities.

See http://www.iom.edu/file.asp?id=19726 for the Institute of Medicine's report on **health literacy** in America. Those who live in Washington state can order the state's free STD pamphlets. Go to the order form at http://www.doh.wa.gov/cfh/STD/publications.htm.

http://www.4woman.gov/mens/index.htm is the male version of this health site. Included are sections on minority health and health disparities.

Here are the web addresses for CDC's updated fact sheets:

BV - http://www.cdc.gov/std/BV/STDFact-Bacterial-Vaginosis.htm

Chlamydia - http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm

Gonorrhea - http://www.cdc.gov/std/Gonorrhea/STDFact-gonorrhea.htm

Herpes - http://www.cdc.gov/std/Herpes/STDFact-Herpes.htm

HPV - http://www.cdc.gov/std/HPV/STDFact-HPV.htm

PID - http://www.cdc.gov/std/PID/STDFact-PID.htm

Syphilis - http://www.cdc.gov/std/Syphilis/STDFact-Syphilis.htm

Trichomoniasis-http://www.cdc.gov/std/Trichomonas/STDFact-Trichomoniasis.htm

STDs & Pregnancy - http://www.cdc.gov/std/STDFact-STDs&Pregnancy.htm

MSM & Syphilis - http://www.cdc.gov/std/STDFact-MSM%26Syphilis.htm

Sexually Transmitted Diseases and HIV Prevention (in an updated format) http://www.cdc.gov/std/STDFact-STD&HIV.htm.

TABLE 1. WASHINGTON STATE HIV[1] AND AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, AS OF 6/30/2004

	TOTAL CASES (& CASE FATALITY RATE[2]) DIAGNOSED DURING INTERVAL[3]					DEATHS OCCURRING DURING INTERVAL[4]		CASES PRESUMED LIVING DIAGNOSED DURING INTERVAL[3]		
	HIV[1]		AIDS		**HIV/AIDS**	*HIV[1]*	AIDS	*HIV[1]*	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**Total**	*No.*	No.	*No.*	No.	**Total**
1982	*2*	*(0%)*	1	(100%)	**3**	*0*	0	*2*	0	**2**
1983	*6*	*(17%)*	20	(100%)	**26**	*0*	7	*5*	0	**5**
1984	*13*	*(0%)*	79	(97%)	**92**	*0*	31	*13*	2	**15**
1985	*68*	*(9%)*	132	(97%)	**200**	*0*	81	*62*	4	**66**
1986	*64*	*(11%)*	250	(98%)	**314**	*0*	128	*57*	6	**63**
1987	*74*	*(11%)*	371	(95%)	**445**	*2*	187	*66*	17	**83**
1988	*83*	*(13%)*	497	(93%)	**580**	*6*	240	*72*	34	**106**
1989	*125*	*(10%)*	629	(91%)	**754**	*8*	312	*112*	57	**169**
1990	*140*	*(12%)*	759	(90%)	**899**	*6*	377	*123*	79	**202**
1991	*151*	*(8%)*	856	(86%)	**1,007**	*4*	477	*139*	121	**260**
1992	*144*	*(8%)*	924	(76%)	**1,068**	*7*	530	*133*	220	**353**
1993	*130*	*(5%)*	998	(66%)	**1,128**	*12*	644	*124*	337	**461**
1994	*174*	*(5%)*	893	(54%)	**1,067**	*5*	687	*165*	409	**574**
1995	*187*	*(3%)*	791	(36%)	**978**	*5*	678	*181*	510	**691**
1996	*221*	*(3%)*	717	(25%)	**938**	*3*	480	*214*	535	**749**
1997	*225*	*(5%)*	534	(19%)	**759**	*7*	234	*214*	433	**647**
1998	*221*	*(2%)*	412	(22%)	**633**	*5*	170	*216*	323	**539**
1999	*284*	*(2%)*	375	(19%)	**659**	*4*	140	*279*	303	**582**
2000	*353*	*(2%)*	453	(18%)	**806**	*28*	160	*345*	370	**715**
2001	*315*	*(1%)*	416	(12%)	**731**	*21*	146	*312*	365	**677**
2002	*319*	*(1%)*	435	(8%)	**754**	*17*	145	*315*	401	**716**
2003[5]	*337*	*(0%)*	429	(5%)	**766**	*11*	157	*336*	406	**742**
2004 YTD[5]	127	*(1%)*	133	(2%)	**260**	1	30	126	131	**257**
TOTAL	*3,763*	*(4%)*	11,104	(54%)	**14,867**	*152*	6,041	*3,611*	5,063	**8,674**

TABLE 2. WASHINGTON STATE HIV[1] AND AIDS CASES, GENDER BY AGE AT DIAGNOSIS.

	HIV[1]						AIDS					
	Male		*Female*		*Total*		Male		Female		Total	
	No.	*(%)*	*No.*	*(%)*	*No.*	*(%)*	No.	(%)	No.	(%)	No.	(%)
Under 13	*17*	*(0%)*	*20*	*(1%)*	*37*	*(1%)*	15	(0%)	17	(0%)	32	(0%)
13-19	*59*	*(2%)*	*37*	*(1%)*	*96*	*(3%)*	30	(0%)	11	(0%)	41	(0%)
20-29	*1,050*	*(28%)*	*206*	*(5%)*	*1,256*	*(33%)*	1,649	(15%)	224	(2%)	1,873	(17%)
30-39	*1,349*	*(36%)*	*170*	*(5%)*	*1,519*	*(40%)*	4,761	(43%)	380	(3%)	5,141	(46%)
40-49	*585*	*(16%)*	*90*	*(2%)*	*675*	*(18%)*	2,675	(24%)	211	(2%)	2,886	(26%)
50-59	*135*	*(4%)*	*21*	*(1%)*	*156*	*(4%)*	779	(7%)	81	(1%)	860	(8%)
60+	*18*	*(0%)*	*6*	*(0%)*	*24*	*(1%)*	241	(2%)	30	(0%)	271	(2%)
TOTAL	*3,213*	*(85%)*	*550*	*(15%)*	*3,763*	*(100%)*	10,150	(91%)	954	(9%)	11,104	(100%)

1 Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

2 Case fatality rate is the proportion of HIV or AIDS patients diagnosed during interval who are known to have died at some time since diagnosis.

3 Year of diagnosis reflects the time at which HIV infection or AIDS was diagnosed by a health care provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

4 Includes deaths among HIV or AIDS patients diagnosed during that interval or any preceding interval.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

IDRH Assessment Unit, P.O. Box 47838, Olympia, WA 98504-7838; (360) 236-3455.

TABLE 3. WASHINGTON STATE HIV[1] CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 6/30/2004

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	2464	(77%)	280	(53%)	13	(35%)	2757	(73%)
Black, not Hispanic	352	(11%)	157	(30%)	14	(38%)	523	(14%)
Hispanic (All Races)	235	(7%)	45	(8%)	6	(16%)	286	(8%)
Asian/Pacific Islander	3	(0%)	4	(1%)	0	(0%)	7	(0%)
Asian	69	(2%)	10	(2%)	4	(11%)	83	(2%)
Hawaiian/Pacific Islander	5	(0%)	1	(0%)	0	(0%)	6	(0%)
Native American/Alaskan	35	(1%)	26	(5%)	0	(0%)	61	(2%)
Multi-race	10	(0%)	1	(0%)	0	(0%)	11	(0%)
Unknown	23	(1%)	6	(1%)	0	(0%)	29	(1%)
Total	3,196	(100%)	530	(100%)	37	(100%)	3,763	(100%)
Exposure Category								
Male/male sex (MSM)	2343	(73%)	N/A	( )	0	(0%)	2343	(62%)
Injecting Drug Use (IDU)	233	(7%)	135	(25%)	0	(0%)	368	(10%)
MSM and IDU	318	(10%)	N/A	( )	0	(0%)	318	(8%)
Transfusion/Transplant	7	(0%)	8	(2%)	0	(0%)	15	(0%)
Hemophilia	12	(0%)	1	(0%)	1	(3%)	14	(0%)
Heterosexual Contact[6]	112	(4%)	271	(51%)	0	(0%)	383	(10%)
Mother at Risk for HIV	0	(0%)	0	(0%)	34	(92%)	34	(1%)
No Identified Risk[7]/Other	171	(5%)	115	(22%)	2	(5%)	288	(8%)
Total	3,196	(100%)	530	(100%)	37	(100%)	3,763	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.
7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.
10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 4. WASHINGTON STATE AIDS CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 6/30/2004

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	8094	(80%)	533	(57%)	15	(47%)	8642	(78%)
Black, not Hispanic	962	(9%)	242	(26%)	10	(31%)	1214	(11%)
Hispanic (All Races)	722	(7%)	80	(9%)	4	(13%)	806	(7%)
Asian/Pacific Islander	34	(0%)	12	(1%)	1	(3%)	47	(0%)
Asian	108	(1%)	15	(2%)	0	(0%)	123	(1%)
Hawaiian/Pacific Islander	20	(0%)	6	(1%)	0	(0%)	26	(0%)
Native American/Alaskan	161	(2%)	43	(5%)	1	(3%)	205	(2%)
Multi-race	23	(0%)	3	(0%)	1	(3%)	27	(0%)
Unknown	11	(0%)	3	(0%)	0	(0%)	14	(0%)
Total	10,135	(100%)	937	(100%)	32	(100%)	11,104	(100%)
Exposure Category								
Male/male sex (MSM)	7421	(73%)	N/A	( )	0	(0%)	7421	(67%)
Injecting Drug Use (IDU)	740	(7%)	285	(30%)	0	(0%)	1025	(9%)
MSM and IDU	1105	(11%)	N/A	( )	0	(0%)	1105	(10%)
Transfusion/Transplant	73	(1%)	49	(5%)	0	(0%)	122	(1%)
Hemophilia	82	(1%)	4	(0%)	4	(13%)	90	(1%)
Heterosexual Contact[6]	265	(3%)	464	(50%)	0	(0%)	729	(7%)
Mother at Risk for HIV	0	(0%)	0	(0%)	28	(88%)	28	(0%)
No Identified Risk[7]/Other	449	(4%)	135	(14%)	0	(0%)	584	(5%)
Total	10,135	(100%)	937	(100%)	32	(100%)	11,104	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.
7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.
10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 5. WA STATE HIV[1] & AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, BY COUNTY OF RESIDENCE[8] AT DIAGNOSIS, AS OF 6/30/2004

	CASES DIAGNOSED					DEATHS				PRESUMED LIVING				
	HIV[1]	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**	*HIV[1]*	*HIV[1]*	AIDS	AIDS	*HIV[1]*	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**TOTAL**	*No.*	*(%)*	No.	(%)	*No.*	*(%)*	No.	(%)	**TOTAL**
REGION 1	*159*	*(4.2%)*	618	(5.6%)	**777**	*11*	*(7.2%)*	329	(5.4%)	*148*	*(4.1%)*	289	(5.7%)	**437**
ADAMS CO.	*1*	*(0.0%)*	5	(0.0%)	**6**	*0*	*(0.0%)*	1	(0.0%)	*1*	*(0.0%)*	4	(0.1%)	**5**
ASOTIN CO.	*3*	*(0.1%)*	14	(0.1%)	**17**	*1*	*(0.7%)*	6	(0.1%)	*2*	*(0.1%)*	8	(0.2%)	**10**
COLUMBIA CO.	*1*	*(0.0%)*	4	(0.0%)	**5**	*0*	*(0.0%)*	3	(0.0%)	*1*	*(0.0%)*	1	(0.0%)	**2**
FERRY CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	6	(0.1%)	*0*	*(0.0%)*	1	(0.0%)	**1**
GARFIELD CO.	*1*	*(0.0%)*	0	(0.0%)	**1**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	0	(0.0%)	**1**
LINCOLN CO.	*0*	*(0.0%)*	4	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*0*	*(0.0%)*	2	(0.0%)	**2**
OKANOGAN CO.	*6*	*(0.2%)*	24	(0.2%)	**30**	*0*	*(0.0%)*	8	(0.1%)	*6*	*(0.2%)*	16	(0.3%)	**22**
PEND OREILLE CO.	*1*	*(0.0%)*	8	(0.1%)	**9**	*0*	*(0.0%)*	5	(0.1%)	*1*	*(0.0%)*	3	(0.1%)	**4**
SPOKANE CO.	*134*	*(3.6%)*	459	(4.1%)	**593**	*9*	*(5.9%)*	255	(4.2%)	*125*	*(3.5%)*	204	(4.0%)	**329**
STEVENS CO.	*4*	*(0.1%)*	23	(0.2%)	**27**	*0*	*(0.0%)*	9	(0.1%)	*4*	*(0.1%)*	14	(0.3%)	**18**
WALLA WALLA CO.	*6*	*(0.2%)*	60	(0.5%)	**66**	*1*	*(0.7%)*	30	(0.5%)	*5*	*(0.1%)*	30	(0.6%)	**35**
WHITMAN CO.	*2*	*(0.1%)*	10	(0.1%)	**12**	*0*	*(0.0%)*	4	(0.1%)	*2*	*(0.1%)*	6	(0.1%)	**8**
REGION 2	*120*	*(3.2%)*	370	(3.3%)	**490**	*7*	*(4.6%)*	187	(3.1%)	*113*	*(3.1%)*	183	(3.6%)	**296**
BENTON CO.	*21*	*(0.6%)*	79	(0.7%)	**100**	*1*	*(0.7%)*	37	(0.6%)	*20*	*(0.6%)*	42	(0.8%)	**62**
CHELAN CO.	*13*	*(0.3%)*	34	(0.3%)	**47**	*1*	*(0.7%)*	21	(0.3%)	*12*	*(0.3%)*	13	(0.3%)	**25**
DOUGLAS CO.	*2*	*(0.1%)*	2	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*2*	*(0.1%)*	0	(0.0%)	**2**
FRANKLIN CO.	*17*	*(0.5%)*	43	(0.4%)	**60**	*1*	*(0.7%)*	13	(0.2%)	*16*	*(0.4%)*	30	(0.6%)	**46**
GRANT CO.	*8*	*(0.2%)*	29	(0.3%)	**37**	*1*	*(0.7%)*	21	(0.3%)	*7*	*(0.2%)*	8	(0.2%)	**15**
KITTITAS CO.	*3*	*(0.1%)*	16	(0.1%)	**19**	*0*	*(0.0%)*	9	(0.1%)	*3*	*(0.1%)*	7	(0.1%)	**10**
KLICKITAT CO.	*5*	*(0.1%)*	11	(0.1%)	**16**	*0*	*(0.0%)*	8	(0.1%)	*5*	*(0.1%)*	3	(0.1%)	**8**
YAKIMA CO.	*51*	*(1.4%)*	156	(1.4%)	**207**	*3*	*(2.0%)*	76	(1.3%)	*48*	*(1.3%)*	80	(1.6%)	**128**
REGION 3	*294*	*(7.8%)*	868	(7.8%)	**1,162**	*16*	*(10.5%*	451	(7.5%)	*278*	*(7.7%)*	417	(8.2%)	**695**
ISLAND CO.	*17*	*(0.5%)*	59	(0.5%)	**76**	*1*	*(0.7%)*	35	(0.6%)	*16*	*(0.4%)*	24	(0.5%)	**40**
SAN JUAN CO.	*6*	*(0.2%)*	18	(0.2%)	**24**	*0*	*(0.0%)*	10	(0.2%)	*6*	*(0.2%)*	8	(0.2%)	**14**
SKAGIT CO.	*23*	*(0.6%)*	52	(0.5%)	**75**	*4*	*(2.6%)*	28	(0.5%)	*19*	*(0.5%)*	24	(0.5%)	**43**
SNOHOMISH CO.	*208*	*(5.5%)*	587	(5.3%)	**795**	*9*	*(5.9%)*	299	(4.9%)	*199*	*(5.5%)*	288	(5.7%)	**487**
WHATCOM CO.	*40*	*(1.1%)*	152	(1.4%)	**192**	*2*	*(1.3%)*	79	(1.3%)	*38*	*(1.1%)*	73	(1.4%)	**111**
REGION 5	*415*	*(11.0%)*	1,183	(10.7%	**1,598**	*26*	*(17.1%*	651	(10.8%	*389*	*(10.8%*	532	(10.5%	**921**
KITSAP CO.	*66*	*(1.8%)*	200	(1.8%)	**266**	*1*	*(0.7%)*	110	(1.8%)	*65*	*(1.8%)*	90	(1.8%)	**155**
PIERCE CO.	*349*	*(9.3%)*	983	(8.9%)	**1,332**	*25*	*(16.4%*	541	(9.0%)	*324*	*(9.0%)*	442	(8.7%)	**766**
REGION 6	*295*	*(7.8%)*	930	(8.4%)	**1,225**	*12*	*(7.9%)*	469	(7.8%)	*283*	*(7.8%)*	461	(9.1%)	**744**
CLALLAM CO.	*16*	*(0.4%)*	51	(0.5%)	**67**	*2*	*(1.3%)*	28	(0.5%)	*14*	*(0.4%)*	23	(0.5%)	**37**
CLARK CO.	*131*	*(3.5%)*	410	(3.7%)	**541**	*2*	*(1.3%)*	208	(3.4%)	*129*	*(3.6%)*	202	(4.0%)	**331**
COWLITZ CO.	*29*	*(0.8%)*	91	(0.8%)	**120**	*1*	*(0.7%)*	50	(0.8%)	*28*	*(0.8%)*	41	(0.8%)	**69**
GRAYS HARBOR CO.	*12*	*(0.3%)*	48	(0.4%)	**60**	*1*	*(0.7%)*	29	(0.5%)	*11*	*(0.3%)*	19	(0.4%)	**30**
JEFFERSON CO.	*7*	*(0.2%)*	24	(0.2%)	**31**	*3*	*(2.0%)*	15	(0.2%)	*4*	*(0.1%)*	9	(0.2%)	**13**
LEWIS CO.	*9*	*(0.2%)*	40	(0.4%)	**49**	*1*	*(0.7%)*	26	(0.4%)	*8*	*(0.2%)*	14	(0.3%)	**22**
MASON CO.	*19*	*(0.5%)*	72	(0.6%)	**91**	*0*	*(0.0%)*	20	(0.3%)	*19*	*(0.5%)*	52	(1.0%)	**71**
PACIFIC CO.	*7*	*(0.2%)*	17	(0.2%)	**24**	*0*	*(0.0%)*	11	(0.2%)	*7*	*(0.2%)*	6	(0.1%)	**13**
SKAMANIA CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	5	(0.1%)	*0*	*(0.0%)*	2	(0.0%)	**2**
THURSTON CO.	*64*	*(1.7%)*	168	(1.5%)	**232**	*2*	*(1.3%)*	77	(1.3%)	*62*	*(1.7%)*	91	(1.8%)	**153**
WAHKIAKUM CO.	*1*	*(0.0%)*	2	(0.0%)	**3**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	2	(0.0%)	**3**
SUBTOTAL	*1,283*	*(34.1%)*	3,969	(35.7%	**5,252**	*72*	*(47.4%*	2,087	(34.5%	*1,211*	*(33.5%*	1,882	(37.2%	**3,093**
REGION 4 (KING) CO	*2,480*	*(65.9%)*	7,135	(64.3%	**9,615**	*80*	*(52.6%*	3,954	(65.5%	*2,400*	*(66.5%*	3,181	(62.8%	**5,581**
STATE TOTAL	*3,763*	*(100%)*	11,104	(100%)	**14,867**	*152*	*(100%)*	6,041	(100%)	*3,611*	*(100%)*	5,063	(100%)	**8,674**

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
8. County of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing..

TABLE 6. WASHINGTON STATE HIV[1] CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 6/30/2004

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2000		2001		2002		2003[5]		2004 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	400	(92%)	1,156	(84%)	1,657	(85%)	3,213	(85%)	287	(81%)	272	(86%)	272	(85%)	286	(85%)	107	(84%)
Female	35	(8%)	216	(16%)	299	(15%)	550	(15%)	66	(19%)	43	(14%)	47	(15%)	51	(15%)	20	(16%)
Total	435	(100%)	1,372	(100%)	1,956	(100%)	3,763	(100%)	353	(100%)	315	(100%)	319	(100%)	337	(100%)	127	(100%)
Race/Ethnicity[10]																		
White, not Hispanic	371	(85%)	1,063	(77%)	1,323	(68%)	2,757	(73%)	229	(65%)	211	(67%)	206	(65%)	220	(65%)	90	(71%)
Black, not Hispanic	41	(9%)	164	(12%)	318	(16%)	523	(14%)	66	(19%)	50	(16%)	67	(21%)	57	(17%)	14	(11%)
Hispanic (All Races)	11	(3%)	89	(6%)	186	(10%)	286	(8%)	37	(10%)	33	(10%)	26	(8%)	37	(11%)	9	(7%)
Asian/Pacific Islander	0	(0%)	1	(0%)	6	(0%)	7	(0%)	2	(1%)	2	(1%)	0	(0%)	0	(0%)	0	(0%)
Asian	3	(1%)	25	(2%)	55	(3%)	83	(2%)	10	(3%)	10	(3%)	7	(2%)	9	(3%)	5	(4%)
Hawaiian/Pacific Islander	1	(0%)	0	(0%)	5	(0%)	6	(0%)	1	(0%)	0	(0%)	0	(0%)	3	(1%)	0	(0%)
Native American/Alaskan	6	(1%)	20	(1%)	35	(2%)	61	(2%)	4	(1%)	5	(2%)	6	(2%)	9	(3%)	5	(4%)
Multi-race	0	(0%)	2	(0%)	9	(0%)	11	(0%)	0	(0%)	1	(0%)	4	(1%)	1	(0%)	3	(2%)
Unknown	2	(0%)	8	(1%)	19	(1%)	29	(1%)	4	(1%)	3	(1%)	3	(1%)	1	(0%)	1	(1%)
Total	435	(100%)	1,372	(100%)	1,956	(100%)	3,763	(100%)	353	(100%)	315	(100%)	319	(100%)	337	(100%)	127	(100%)
Exposure Category																		
Male/male sex (MSM)	297	(68%)	839	(61%)	1,207	(62%)	2,343	(62%)	197	(56%)	185	(59%)	200	(63%)	209	(62%)	77	(61%)
Injecting Drug Use (IDU)	47	(11%)	137	(10%)	184	(9%)	368	(10%)	47	(13%)	27	(9%)	28	(9%)	26	(8%)	12	(9%)
MSM and IDU	50	(11%)	119	(9%)	149	(8%)	318	(8%)	25	(7%)	25	(8%)	28	(9%)	27	(8%)	9	(7%)
Transfusion/Transplant	3	(1%)	7	(1%)	5	(0%)	15	(0%)	1	(0%)	2	(1%)	0	(0%)	0	(0%)	1	(1%)
Hemophilia	9	(2%)	4	(0%)	1	(0%)	14	(0%)	1	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Heterosexual Contact[6]	12	(3%)	140	(10%)	231	(12%)	383	(10%)	46	(13%)	40	(13%)	42	(13%)	42	(12%)	17	(13%)
Mother at Risk for HIV	3	(1%)	25	(2%)	6	(0%)	34	(1%)	2	(1%)	0	(0%)	0	(0%)	1	(0%)	0	(0%)
No Identified Risk[7]/Other	14	(3%)	101	(7%)	173	(9%)	288	(8%)	34	(10%)	36	(11%)	21	(7%)	32	(9%)	11	(9%)
Total	435	(100%)	1,372	(100%)	1,956	(100%)	3,763	(100%)	353	(100%)	315	(100%)	319	(100%)	337	(100%)	127	(100%)
AIDSNET Region																		
Region 1	23	(5%)	54	(4%)	82	(4%)	159	(4%)	16	(5%)	15	(5%)	15	(5%)	12	(4%)	6	(5%)
Region 2	11	(3%)	39	(3%)	70	(4%)	120	(3%)	10	(3%)	10	(3%)	15	(5%)	11	(3%)	4	(3%)
Region 3	32	(7%)	127	(9%)	135	(7%)	294	(8%)	20	(6%)	22	(7%)	16	(5%)	26	(8%)	12	(9%)
Region 5	41	(9%)	167	(12%)	207	(11%)	415	(11%)	46	(13%)	26	(8%)	36	(11%)	40	(12%)	7	(6%)
Region 6	30	(7%)	118	(9%)	147	(8%)	295	(8%)	16	(5%)	30	(10%)	25	(8%)	29	(9%)	14	(11%)
Subtotal	137	(31%)	505	(37%)	641	(33%)	1,283	(34%)	108	(31%)	103	(33%)	107	(34%)	118	(35%)	43	(34%)
Region 4 (King Co.)	298	(69%)	867	(63%)	1,315	(67%)	2,480	(66%)	245	(69%)	212	(67%)	212	(66%)	219	(65%)	84	(66%)
Total	435	(100%)	1,372	(100%)	1,956	(100%)	3,763	(100%)	353	(100%)	315	(100%)	319	(100%)	337	(100%)	127	(100%)

1 This includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. It does not include those who have only been tested anonymously for HIV.

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 7. WASHINGTON STATE AIDS CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 6/30/2004

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2000		2001		2002		2003[5]		2004 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	1,915	(97%)	5,956	(92%)	2,279	(86%)	10,150	(91%)	388	(86%)	367	(88%)	363	(83%)	360	(84%)	108	(81%)
Female	64	(3%)	516	(8%)	374	(14%)	954	(9%)	65	(14%)	49	(12%)	72	(17%)	69	(16%)	25	(19%)
Total	1,979	(100%)	6,472	(100%)	2,653	(100%)	11,104	(100%)	453	(100%)	416	(100%)	435	(100%)	429	(100%)	133	(100%)
Race/Ethnicity[10]																		
White, not Hispanic	1,733	(88%)	5,138	(79%)	1,771	(67%)	8,642	(78%)	305	(67%)	273	(66%)	280	(64%)	278	(65%)	90	(68%)
Black, not Hispanic	132	(7%)	639	(10%)	443	(17%)	1,214	(11%)	84	(19%)	76	(18%)	79	(18%)	68	(16%)	23	(17%)
Hispanic (All Races)	78	(4%)	438	(7%)	290	(11%)	806	(7%)	44	(10%)	46	(11%)	46	(11%)	56	(13%)	10	(8%)
Asian/Pacific Islander	3	(0%)	32	(0%)	12	(0%)	47	(0%)	0	(0%)	3	(1%)	4	(1%)	1	(0%)	0	(0%)
Asian	11	(1%)	70	(1%)	42	(2%)	123	(1%)	3	(1%)	5	(1%)	12	(3%)	9	(2%)	2	(2%)
Hawaiian/Pacific Islander	5	(0%)	10	(0%)	11	(0%)	26	(0%)	3	(1%)	0	(0%)	2	(0%)	5	(1%)	1	(1%)
Native American/Alaskan	16	(1%)	124	(2%)	65	(2%)	205	(2%)	8	(2%)	11	(3%)	11	(3%)	9	(2%)	5	(4%)
Multi-race	1	(0%)	17	(0%)	9	(0%)	27	(0%)	3	(1%)	0	(0%)	0	(0%)	3	(1%)	2	(2%)
Unknown	0	(0%)	4	(0%)	10	(0%)	14	(0%)	3	(1%)	2	(0%)	1	(0%)	0	(0%)	0	(0%)
Total	1,979	(100%)	6,472	(100%)	2,653	(100%)	11,104	(100%)	453	(100%)	416	(100%)	435	(100%)	429	(100%)	133	(100%)
Exposure Category																		
Male/male sex (MSM)	1,521	(77%)	4,410	(68%)	1,490	(56%)	7,421	(67%)	259	(57%)	241	(58%)	233	(54%)	241	(56%)	72	(54%)
Injecting Drug Use (IDU)	86	(4%)	612	(9%)	327	(12%)	1,025	(9%)	57	(13%)	45	(11%)	50	(11%)	48	(11%)	20	(15%)
MSM and IDU	236	(12%)	643	(10%)	226	(9%)	1,105	(10%)	35	(8%)	38	(9%)	39	(9%)	30	(7%)	11	(8%)
Transfusion/Transplant	47	(2%)	65	(1%)	10	(0%)	122	(1%)	3	(1%)	0	(0%)	1	(0%)	1	(0%)	0	(0%)
Hemophilia	30	(2%)	53	(1%)	7	(0%)	90	(1%)	3	(1%)	1	(0%)	0	(0%)	1	(0%)	0	(0%)
Heterosexual Contact[6]	29	(1%)	386	(6%)	314	(12%)	729	(7%)	51	(11%)	52	(13%)	70	(16%)	55	(13%)	16	(12%)
Mother at Risk for HIV	8	(0%)	18	(0%)	2	(0%)	28	(0%)	2	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
No Identified Risk[7]/Other	22	(1%)	285	(4%)	277	(10%)	584	(5%)	43	(9%)	39	(9%)	42	(10%)	53	(12%)	14	(11%)
Total	1,979	(100%)	6,472	(100%)	2,653	(100%)	11,104	(100%)	453	(100%)	416	(100%)	435	(100%)	429	(100%)	133	(100%)
AIDSNET Region																		
Region 1	80	(4%)	367	(6%)	171	(6%)	618	(6%)	34	(8%)	21	(5%)	30	(7%)	27	(6%)	8	(6%)
Region 2	49	(2%)	203	(3%)	118	(4%)	370	(3%)	19	(4%)	18	(4%)	15	(3%)	22	(5%)	9	(7%)
Region 3	113	(6%)	534	(8%)	221	(8%)	868	(8%)	29	(6%)	31	(7%)	42	(10%)	39	(9%)	5	(4%)
Region 5	173	(9%)	679	(10%)	331	(12%)	1,183	(11%)	72	(16%)	60	(14%)	40	(9%)	37	(9%)	17	(13%)
Region 6	111	(6%)	568	(9%)	251	(9%)	930	(8%)	34	(8%)	53	(13%)	50	(11%)	29	(7%)	16	(12%)
Subtotal	526	(27%)	2,351	(36%)	1,092	(41%)	3,969	(36%)	188	(42%)	183	(44%)	177	(41%)	154	(36%)	55	(41%)
Region 4 (King Co.)	1,453	(73%)	4,121	(64%)	1,561	(59%)	7,135	(64%)	265	(58%)	233	(56%)	258	(59%)	275	(64%)	78	(59%)
Total	1,979	(100%)	6,472	(100%)	2,653	(100%)	11,104	(100%)	453	(100%)	416	(100%)	435	(100%)	429	(100%)	133	(100%)

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

WASHINGTON STATE REPORTED CASES OF CHLAMYDIA, GONORRHEA, EARLY SYPHILIS, JANUARY - JUNE 2004

	Chlamydia		Gonorrhea		Early Syphilis	
Sex	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Male	2,396	(27.1)	730	(54.6)	70	(98.6)
Female	6,460	(72.9)	608	(45.4)	1	(1.4)
TOTAL	**8,856**	**(100)**	**1,338**	**(100)**	**71**	**(100)**
Age						
0-14	124	(1.4)	14	(1.0)	0	(0.0)
15-19	2,909	(32.8)	286	(21.4)	0	(0.0)
20-24	3,378	(38.1)	337	(25.2)	4	(5.6)
25-29	1,306	(14.7)	215	(16.1)	10	(14.1)
30-34	537	(6.1)	155	(11.6)	17	(23.9)
35-39	266	(3.0)	138	(10.3)	17	(23.9)
40+	242	(2.7)	186	(13.9)	23	(32.4)
Unknown	94	(1.1)	7	(0.5)	0	(0.0)
TOTAL	**8,856**	**(100)**	**1,338**	**(100)**	**71**	**(100)**
Ethnic/Race						
White	4,150	(46.9)	588	(43.9)	40	(56.3)
Black	1,108	(12.5)	288	(21.5)	10	(14.1)
Hispanic	1,329	(15.0)	152	(11.4)	9	(12.7)
Native Hawaiian/Other Pacific Islander	91	(1.0)	7	(0.5)	0	(0.0)
Asian	605	(6.8)	59	(4.4)	2	(2.8)
Native American	275	(3.1)	39	(2.9)	3	(4.2)
Multi	0	(0.0)	0	(0.0)	0	(0.0)
Other	54	(0.6)	5	(0.4)	0	(0.0)
Unknown	1,244	(14.0)	200	(14.9)	7	(9.9)
TOTAL	**8,856**	**(100)**	**1,338**	**(100)**	**71**	**(100)**

Provider Type	**Cases**	**# Prov**	**Cases**	**# Prov**	**Cases**	**# Prov**
Community Health Ctr.	287	33	69	17	7	2
Emergency Care (Not Hosp.)	148	40	40	18	1	1
Family Planning	2,026	50	129	30	0	0
Health Plan/HMO's	259	37	38	18	2	2
Hospitals	777	81	184	46	3	2
Indian Health	113	16	18	7	2	2
Jail/Correction/Detention	301	30	62	15	0	0
Migrant Health	283	20	31	12	1	1
Military	355	9	45	7	4	3
Neighborhood Health	71	12	12	7	0	0
OB/GYN	568	97	50	30	0	0
Other	1,698	441	264	149	21	13
Private Physician	214	109	33	26	12	6
Reproductive Health	711	18	68	14	1	1
STD	694	26	266	12	17	3
Student Health	351	25	29	9	0	0
TOTAL	**8,856**	**1,044**	**1,338**	**417**	**71**	**36**

WASHINGTON STATE REPORTED STDS BY COUNTY JANUARY - JUNE 2004

	CT	GC	HERPES	P & S	EL	L/LL	CONG	TOTAL
Adams	8	1	0	-	-	-	-	0
Asotin	19	1	5	-	-	-	-	0
Benton	214	8	23	-	-	1	-	1
Chelan	70	0	12	-	-	-	-	0
Clallam	74	4	15	-	-	-	-	0
Clark	418	79	23	1	1	-	-	2
Columbia	2	0	0	-	-	-	-	0
Cowlitz	110	16	9	-	-	1	-	1
Douglas	44	2	5	-	-	-	-	0
Ferry	7	0	3	-	-	-	-	0
Franklin	95	2	2	-	-	-	-	0
Garfield	0	0	0	-	-	-	-	0
Grant	127	5	17	-	-	-	-	0
Grays Harbor	93	2	4	-	-	-	-	0
Island	89	9	18	1	-	1	-	2
Jefferson	20	2	5	-	-	-	-	0
King	2,671	585	376	35	15	36	-	86
Kitsap	351	30	28	3	1	-	-	4
Kittitas	49	0	6	-	-	-	-	0
Klickitat	27	5	2	-	-	-	-	0
Lewis	108	5	6	-	-	-	-	0
Lincoln	7	1	1	-	-	-	-	0
Mason	59	2	9	1	-	3	-	4
Okanogan	72	2	10	-	-	1	-	1
Pacific	19	1	2	-	-	-	-	0
Pend Oreille	5	0	2	-	-	-	-	0
Pierce	1,373	239	110	4	-	7	-	11
San Juan	11	0	1	-	-	-	-	0
Skagit	146	10	38	-	-	-	-	0
Skamania	5	1	1	-	-	-	-	0
Snohomish	803	88	139	4	2	5	-	11
Spokane	566	73	87	-	-	3	-	3
Stevens	21	1	2	-	-	-	-	0
Thurston	275	21	34	2	-	1	-	3
Wahkiakum	2	0	0	-	-	-	-	0
Walla Walla	71	3	12	-	-	-	-	0
Whatcom	242	44	56	-	-	1	-	1
Whitman	74	4	5	-	-	-	-	0
Yakima	509	92	72	-	1	5	-	6
YEAR TO DATE	8,856	1,338	1,140	51	20	65	0	136
PRV YR TO DATE	7,965	1,433	973	38	22	61	0	121
% CHANGE	+11.2%	-6.6%	+17.2%	+34.2%	-9.1%	+6.6%	NC	+12.4%

CT = Chlamydia Trachomatis
GC = Gonorrhea
HERPES = Initial Genital Herpes
P/S = Primary & Secondary Syphilis
EL = Early Latent Syphilis
L/LL = Late/Late Latent Syphilis
CONG = Congenital Syphilis

MONTHLY TUBERCULOSIS CASE TOTALS BY COUNTY, 2003-2004

	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEP		OCT		NOV		DEC		TOTAL	
COUNTY	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**2004**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**2004**
Adams					1																				**1**	**0**
Asotin																									**0**	**0**
Benton				1						2			1										1		**2**	**3**
Chelan					1								3												**4**	**0**
Clallam	1																								**1**	**0**
Clark							1	1		1		2			4				1		3		1		**10**	**4**
Columbia																									**0**	**0**
Cowlitz													1												**1**	**0**
Douglas					1		1																		**2**	**0**
Ferry																									**0**	**0**
Franklin				1	1		1			1	1		2												**5**	**2**
Garfield																									**0**	**0**
Grant							2												1						**3**	**0**
Grays Harbor	1																								**1**	**0**
Island	1									1															**1**	**1**
Jefferson																									**0**	**0**
King	10	8	14	12	12	7	17	15	14	6	3	19	20		18		13		10		9		15		**155**	**67**
Kitsap									1														1		**2**	**0**
Kittitas								1																	**0**	**1**
Klickitat																									**0**	**0**
Lewis				1															1				1		**2**	**1**
Lincoln																									**0**	**0**
Mason			1		1																		1		**3**	**0**
Okanogan									1				1												**2**	**0**
Pacific																									**0**	**0**
Pend-Oreille																									**0**	**0**
Pierce	1	1	1	2		1	2	2	1	1		9	2		2		1		4		2		2		**18**	**16**
San Juan																									**0**	**0**
Skagit												1					1		1						**2**	**1**
Skamania																									**0**	**0**
Snohomish	3				2		1			1		2	1		1		2						2		**12**	**3**
Spokane		3		1	1	1							3												**4**	**5**
Stevens																									**0**	**0**
Thurston				1			1			1		1	1										3		**5**	**3**
Wahkiakum																									**0**	**0**
Walla Walla							1																		**1**	**0**
Whatcom		1				1	1	1	1			1	1								1		1		**5**	**4**
Whitman																									**0**	**0**
Yakima	1	2		3		1		1		1	2		2						1		1		1		**8**	**8**
State Total	**18**	**15**	**16**	**22**	**20**	**11**	**28**	**21**	**18**	**15**	**6**	**35**	**38**	**0**	**25**	**0**	**17**	**0**	**19**	**0**	**16**	**0**	**29**	**0**	**250**	**119**
YTD State Total	**18**	**15**	**34**	**37**	**54**	**48**	**82**	**69**	**100**	**84**	**106**	**119**	**144**	**119**	**169**	**119**	**186**	**119**	**205**	**119**	**221**	**119**	**250**	**119**	**250**	**119**

Note: Detailed analysis of tuberculosis morbidity is contained in "Washington State Tuberculosis Epidemiological Profile - 1998" and is available to order from the State TB Program by calling (360) 236-3443.

Deadline Details For *Washington State Responds* Quarterly Newsletter

The deadline for the next issue of ***Washington State Responds*** is **September 20, 2004**. The calendar start date for the issue is **November 5, 2004**. To submit information, corrections, or to be added or dropped from the mailing list, contact Barbara Schuler, Washington State Department of Health, HIV Prevention and Education Services, P.O. Box 47840, Olympia, WA 98504-7840. You may also telephone her at: (360) 236-3487 or call the Washington State Hotline at **1-800-272-2437, ext. 0** to leave a message**.** You may fax your information to (360) 236-3400, or preferably send via e-mail to:barbara.schuler@ doh.wa.gov

We greatly appreciate news of your work or your organization!

Thank you for taking the time and effort to write, call, fax or e-mail!

DOH HIV/AIDS Prevention and Education Services

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Washington State Department of Health HIV/AIDS Prevention and Education Services publishes information in this quarterly newsletter, ***Washington State Responds,*** as a courtesy to our readers, however, inclusion of information coming from outside of the Washington State Department of Health does not necessarily imply endorsement by the Washington State Department of Health.

The content of this newsletter is for informational purposes only and is not intended to be a substitute for professional medical advice, diagnosis or treatment.

This newsletter may contain HIV prevention messages that may not be appropriate for all audiences. Since HIV infection is spread primarily through sexual practices or by sharing syringe needles, prevention messages and programs may address these topics. If you are not seeking such information or are offended by such materials, do not visit this site.